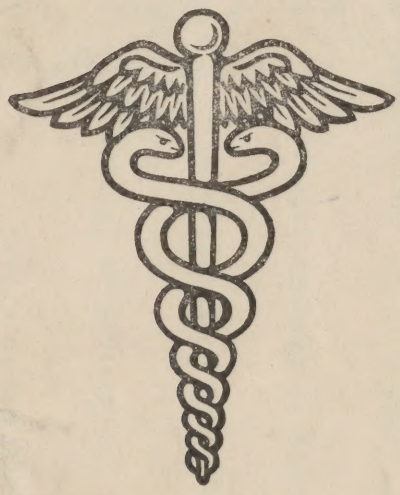
RECONDITIONING CONFERENCE

FIFTH AND SIXTH SERVICE COMMANDS

10-11 APRIL 1944



U.S. ARMY SERVICE FORCES
FIFTH SERVICE COMMAND
NICHOLS GENERAL HOSPITAL
LOUISVILLE, KY.

O.T. DEPT.

REVISED

ARMY SERVICE FORCES
Fifth Service Command
Nichols General Hospital
Louisville 2, Kentucky

RECONDITIONING CONFERENCE FIFTH AND SIXTH SERVICE COMMANDS

10 and 11 April 1944.

FIRST DAY

9:30 A. M.	Conference called to order.	Colonel E. C. Jones, MC, 5th SvC Surgeon, Chairman.
9:30 A. M. 9:40 A. M.	Welcome by the Commanding Officer.	Colonel Wm. W. Southard, MC, Commanding, Nichols General Hospital.
9:40 A. M. 10:00 A. M.	The Origin of the Reconditioning Program.	Brig. Gen. C. C. Hillman, Chief Professional Service, SGO, Wash, DC.
10:00 A. M. 10:20 A. M.	The Objectives of Reconditioning.	Colonel Augustus Thorndike, Director Reconditioning Division, SGO, Wash, DC.
10:20 A. M. 10:35 A. M.	The Service Command in the Reconditioning Program.	Major Gen. James L. Collins, Commanding General 5th Service Command.
10:35 A. M. 10:55 A. M.	Conservation of Trained Personnel.	Colonel Wm. Blakely, GSC, WD, Wash, DC.
10:55 A. M. 11:10 A. M.	RECESS.	

11:00 A.M. 11:10 A.M.	Practical Observations at Nichols General Hospital	Lt Colonel John G. Snelling, Jr, MC Executive Officer, Nichols Gen Hospital
11:10 A.M. 11:25 A.M.	Reconditioning of the Psychoneurotic at Nichols General Hospital	Captain Samuel Silverman, MC, Chief of Psychiatric Section, Nichols Gen Hospital
11:25 A.M. 11:30 A.M.	Message from General Dalton	Colonel John W. Childs, GSC, Dir. of Pers. Div, SGO, Wash, D.C.
11:30 A.M. 11:40 A.M.	Reconditioning Program from Viewpoint of Patient Officer.	Lt. Colonel Ralph T. Hilton, Sig. C, Patient, Nichol's Gen. Hospital.
11:40 A.M. 12:10 A.M.	Physical Reconditioning	Dr. C. H. McCloy, Prof. Physical Education, University of Iowa, Civilian Consultant on Physical Reconditioning, SGO
1:00 P.M. 2:00 P.M.	Mess	
2:00 P.M.	Conference called to order.	Colonel Don G. Hilldrup, MC, 6th SvC Surgeon
2:05 P.M. 2:25 P.M.	Educational factor in reconditioning	Captain Edward Evans, Morale Services Div, ASF, Wash, DC.
2:25 P.M. 2:45 P.M.	Orientation of soldier patient	Lt. David Humphreys, Morale Service Div, Wash, DC.
2:50 P.M. 3:05 P.M.	The Therapeutic Importance of Occupational Therapy	Mrs. Winifred Kahmann, Wash, DC.
3:05 P.M. 3:25 P.M.	RECESS	
3:25 P.M. 3:45 P.M.	Observations by the Commanding Officer	Colonel Wm. W. Southard, MC, Commanding, Nichols General Hospital
3:45 P.M. 4:15 P.M.	The Reconditioning Program at Nichols General Hospital	Major Robert L. Preston, MC, Reconditioning Officer, Nichols General Hospital.

4:15 P. M. 4:30 P. M.	Organizational Problems.	Colonel Augustus Thorndike, MC, Director, Reconditioning Division, SGO, Wash, DC.
4:30 P. M. 4:50 P. M.	Discussion.	Brig. Gen. C. C. Hillman, Chief Professional Service, SGO, Wash, DC.
5:00 P. M. 5:30 P. M.	Retreat Parade - Headquarters.	
5:30 P. M. 6:50 P. M.	Informal Conference - Officers' Club.	
7:00 P. M. 8:00 P. M.	Mess.	
8:00 P. M. 10:00 P. M.	Panel Discussion.	Major Gen. Joe E. Dalton or his Representative. Colonel Wm. Blakely. Major Gen. Miller G. White or his Representative. Colonel Augustus Thorndike " " " Major William S. Briscoe " " " Mrs. Winifred Kahmann " " Colonel Wm. W. Southard " " "

SECOND DAY

8:00 A. M.	Conference called to order by the Commanding Officer.
8:00 A. M. 11:15 A. M.	Demonstration of Reconditioning Program.
11:30 A. M. 12:15 P. M.	Mess.
12:15 P. M.	Reconvene at Conference Room - Adjournment.

ARMY SERVICE FORCES
Fifth Service Command
Nichols General Hospital
Louisville 2, Kentucky

OFFICERS ATTENDING RECONDITIONING CONFERENCE FIFTH AND SIXTH SERVICE COMMANDS - 10 and 11 APRIL 1944

MAJOR GENERALS		
Collins, James L.	USA	CG, 5th SvC, Fort Hayes, Columbus, Ohio
Porter, Ray E.	USA	Asst Chief of Staff, G-3, WD, Wash, DC
White, Miller G.	USA	Asst Chief of Staff, G-1, WD, Wash, DC
BRIGADIER GENERALS		
Baylis, James E.	USA	CG, MDRTC, Camp Grant, Illinois
Bastion, Joseph E.	USA	CG, Percy Jones GH, Battle Creek, Michigan
Carroll, Percy J.	USA	CG, Vaughan GH, Hines, Illinois
Hillman, Charles C.	USA	Chief of Professional Service, SGO, Wash, DC
COLONELS		
Beck, Clyde M.	MC	CO, Ashford GH, White Sulphur Springs, W. Va.
Blakely, William M.	GSC	WD, Wash, DC
Bowers, Berna T.	MC	Crile GH, Cleveland, Ohio
Childs, John W.	GSC	Director of Personnel Div, SGO, Wash, DC
Conner, Haskett L.	MC	Camp Atterbury, Indiana
Cook, Everett L.	MC	CO, Newton D. Baker GH, Martinsburg, W. Va.
Dale, Harry L.	MC	CO, Billings GH, Fort Benjamin Harrison, Indiana
Darby, Taylor E.	MC	CO, Fletcher GH, Cambridge, Ohio
Hall, John R.	MC	CO, Gardiner GH, Chicago, Illinois
Hilldrup, Don G.	MC	SvC Surgeon, 6th SvC, Chicago, Illinois
Jackson, Harry D.	MC	Camp Surgeon, Camp Breckinridge, Kentucky
Jacobson, H. A.	MC	6th Service Command
Jones, Edgar C.	MC	SvC Surgeon, 5th SvC, Fort Hayes, Columbus, Ohio
Krafft, Henry L.	MC	CO, Mayo GH, Galesburg, Illinois
Martin, Walter B.	MC	Medical Consultant, 5th SvC, Fort Hayes, Ohio
Moose, Frank McA	MC	Post Surgeon, Fort Knox, Kentucky
O'Connor, Charles M.	MC	Camp Surgeon, Camp Grant, Illinois
Odom, Cleve C.	MC	CO, Darnall GH, Danville, Kentucky
Odom, Stanley G.	MC	Post Surgeon, Fort Hayes, Columbus, Ohio
Ostrander, Forrest F.	MC	CO, Crile GH, Cleveland, Ohio
Patton, Thomas E.	MC	Camp Surgeon, Camp McCoy, Wisconsin
Redland, Arthur J.	MC	Asst SvC Surgeon, 5th SvC, Fort Hayes, Ohio
Schwartz, Seymour C.	MC	Post Surgeon, Fort Thomas, Kentucky
Southard, William W.	MC	CO, Nichols GH, Louisville, Kentucky
Thorndike, Augustus	MC	Director Reconditioning Div, SGO, Wash, DC
VanHook, Henry N.	MC	Camp Surgeon, Camp Campbell, Kentucky
LIEUTENANT COLONELS		
Arnett, Thomas M.	MC	Newton D. Baker GH, Martinsburg, W.Va.
Albus, William R.	MC	Hq, 6th SvC, Chicago, Illinois
Beck, Claude S.	MC	Surgical Consultant, 5th SvC, Fort Hayes, Ohio

LIEUTENANT COLONELS Contd.

Collisi, Harrison S.	MC	Post Surgeon, Fort Benjamin Harrison, Indiana
DuPriest, Robert W.	MC	Vaughan GH, Hines, Illinois
Fleetwood, Raymond A.	MC	Camp Atterbury, Indiana
Snelling, John G. Jr,	MC	Executive Officer, Nichols GH, Louisville, Kentucky

MAJORS

Becker, George H.	MC	Camp Campbell, Kentucky
Benbow, Spender D.	AUS	Morale Service Division, Wash, DC
Briscoe, William S.	MC	Educational Reconditioning Officer, SGO, Wash, DC
McCormick, Donald W.	MC	Fort Custer, Michigan
Olsen, Albert L.	MC	Erie Proving Ground, Lacarne, Ohio
Preston, Robert L.	MC	Reconditioning Officer, Nichols GH, Louisville, Ky.
Reed, Joseph	SC	Morale Service Division, ASF, Wash, DC
Rizzo, Peter C. I.	MC	Fletcher GH, Cambridge, Ohio
Smith, Ivan C.	MC	Billings GH, Fort Benjamin Harrison, Indiana

CAPTAINS

Andre, Harvey N.	MC	Camp Atterbury, Indiana
Evans, Edward	AUS	Morale Service Division, ASF, Wash, DC
Goldenberg, Max	MC	Crile GH, Cleveland, Ohio
Hammersley, George K.	MC	Camp Breckinridge, Kentucky
Henderson, Clyde W.	MAC	Adjutant, Nichols GH, Louisville, Kentucky
Levensen, Carl	MC	Ashford GH, White Sulphur Springs, W.Va.
Lyon, Ralph M.	INF	Education O,Reconditioning Sec,NGH,Louisville,Ky.
Revenaugh, V.D.	MAC	6th Service Command
Snyder, Albert J.	MC	Asst Reconditioning O,Nichols GH, Louisville, Ky.
Teal, Frederick F.	MC	Orthopedic Section, Nichols GH, Louisville, Ky.
Vaughan, James C.	MAC	Mayo GH, Galesburg, Illinois

1ST LIEUTENANTS

Humphrey, David	AUS	Morale Service Division, Washington, DC

2D LIEUTENANTS

Garratt, Lauret D.	MAC	Asst Reconditioning O, Nichols GH, Louisville, Ky.
Gross, Joseph G.	MAC	Fort Knox, Kentucky
Hochsprung, Raymond P.	MAC	Asst Reconditioning O, Nichols GH, Louisville, Ky.
Stewart, James E. Jr.	MAC	Darnall GH, Danville, Kentucky

CIVILIANS

Kahmann, Mrs. Winifred	Washington, DC
McCloy, Dr. C. H.	Reconditioning Division, SGO, Washington, DC.

INTRODUCTION

COLONEL JONES:

The meeting will please come to order!

This conference is held for the purpose of telling us something about, and getting us familiar with, a plan none of us know anything about. We have men to tell us all about it. The Surgeon General is very much interested in it, also the various branches of the General Staff, up to and including the Chief of Staff. That is evident since they allowed us to have this meeting. We have the very best men to tell us about it.

There have been a few changes made in the program. There is one thing I want to mention now. We are not conducting this meeting with questions after each speaker. There will be a panel discussion tonight at 8:00 P.M. As the speaker goes along, please make note of anything you don't understand, and put it in the form of a question and turn it in this afternoon at the end of the meeting. This will give us an opportunity to look them over and have them answered. Take advantage of that. Note whatever you don't understand, or any questions you want answered, so they can be taken up at the panel meeting at 8:00 P.M. tonight.

This program was gotten up and represents quite a good deal of work on the part of Colonel Southard and his personnel here. They had a very good program set up until we came along and messed it up. We had to do it on account of the train schedules. The meeting will close at noon tomorrow. This could not be helped because a good many men have to get back. Colonel Southard, with the help of Colonel Martin, worked this up and it is something I think we will all get a great deal out of.

Colonel Southard --

COLONEL SOUTHARD:

Colonel Jones, General Collins and Conferees. The first thing I want to do is welcome you here. Nichols is highly honored in being selected as the seat of this conference and we appreciate the privilege of acting as host to so many distinguished officers and guests. We shall do our best to make you as comfortable as we can with what we have and if the going is rough in spots we bespeak your tolerence. The main thing is -- we are glad to have you here and let there be no doubt as to the sincerity of your welcome.

Upon your arrival you were given certain schedules in the form of programs, schedules and orientation lay-outs. Among the extra curricular activities on the program will be the Retreat at 5:00 P. M. this evening at the Flag Pole in front of the Administration Building, weather permitting, and I think it will permit today. It would be our very great pleasure to have as many of you be present at this ceremony as find it convenient to do so. Immediately following Retreat Parade, informal group discussions will be held in the Officers' Club. Supper will be at 7:00 o'clock at the Enlisted Patients' Mess Hall which is marked on the orientation lay-out plan which we have given you. The panel discussion will be at 8:00 tonight in this room. Please fill out the question cards that are on your desk and leave them exposed on the desk so that they can be picked up before the Retreat Parade.

The program for this conference is so arranged that the first day will be given over entirely to papers, discussions and conferences in this room. Tomorrow morning will be devoted to demonstrations seasoned with discussions and the answering of questions. There will be some walking to do and this is where the conferees will get their reconditioning! At the close of the conference on the second day you will all want transportation to town. You may apply at the Conference Registration Office and make arrangements for that. You all know where it is as you registered there as you came in. Bus and taxi service are available at the main gate for those who may wish transportation for personal errands.

We expect to have a copy of this conference at the adjournment meeting at 12:15 tomorrow.

The hospital may appear somewhat of a labyrinth to some of you, so I have placed additional M.P.'s at convenient points to act as guides for your convenience. When you see these M.P. don't let yourself be persuaded that I have taken extra security precautions due to your presence on the Post! The hospital is now yours! Thank you Colonel Jones.

COLONEL JONES:

At one spectacular time in my career, I was put in charge of organizing a mule-drawn ambulance unit. In addition to our other complications, many of the men and officers had never before been personally acquainted with a mule. But our unit was organized and functioned.

Some of the men were later transferred, and as you know, when an officer leaves, you are supposed to put in an efficiency report. I put one in on this lieutenant as one of the best "mule skinners" I have ever seen. What I was trying to put over was, he had taken on a job of which he knew nothing, and made a success of it.

Today that man wears a star. He is in the Surgeon General's Office and has been put in charge of the Reconditioning Program. I know he will do his best, and as good a job as when he helped me "skin mules". I present Brigadier General C. C. Hillman, Chief Professional Service, SGO, Washington, D. C.

BRIG. GENERAL HILLMAN:

Major General Collins, Colonel Jones and Friends of the Conference.

Those were the days I would say when we could skin mules instead of doing some of the things we have to do these days. I am not referring to reconditioning; it is a matter of real interest and a joy to be connected with. Now that we have the material to work with, personnel, we feel on the way, and the interest of not only our hospital commanders but also of the highest echelon of the War Department. We feel we are on the road to doing some really constructive work in the matter of reconditioning patients in our Army hospitals. I believe it was approximately one hundred years ago that Darwin called attention to the fact that in both the individual and the species anatominal development and perfection of function grow with use; also that physical and functional atrophy invariably accompany prolonged diminution activity. Physicians have long observed the physical deterioration that takes place in their patients with long confinement in bed because of illness, injuries, or operations. We have all seen the patient that has stayed in bed for weeks and months with a fractured leg and though the bone may be well knit when he gets up and about, he is still so out of condition his muscles are so reduced in volume and tone it takes weeks or months of ambulatory convalescence before that individual is fit for any sort of service. Neither is this deterioration confined to the anatomical structures; mental impairment as surely follows prolonged cessation of constructive thought. That aphorism of our childhood that "an idle brain is the devil's workshop" is no better exemplified than in the mind of the unoccupied soldier in a hospital ward.

Esprit de Corps unit objectives and the will to fight tend to give way to self interest, mental lethargy, introspection and the development of escape mechanisms.

With the critical shortage of manpower we have become keenly conscious of the wastage that all of this entails. We have asked ourselves, and others have pointedly asked us, why in these perilous times a man's mind and body should be allowed to lie wholly idle while one small portion of his anatomy is recovering from an operation, injury or other pathological process. Why not keep the rest of the muscles fit through appropriate exercise. Why not fill the hours with constructive thoughtdirected toward the individual's military objective as far as practicable.

It was early in 1943 that serious consideration of these problems pointed to the need of corrective administrative action. Credit is due especially to Brig. General Hugh J. Morgan, Chief Medical Consultant, in The Surgeon General's Office, and Major General David N. W. Grant, the Air Surgeon, for constructive thought on this subject.

On several inspection trips General Morgan came back and this was a point of very earnest discussion, "What can we do with patients on hospital wards? They are lying there reading more or less tattered and obsolete periodicals, movie magazines and all sorts of things," and it seemed to him quite apparent there was quite a degree of mental deterioration fostering unfavorable trends of thought through this idleness of patients on our hospital wards. As a result of his interest, we worked up a memorandum providing for the reconditioning of patients in Army hospitals and it was issued as a War Department Memorandum on 11 February 1943. Due to General Grant's keen appreciation of the problem there has been developed in the Army Air Forces Hospital a very effective program of mental as well as physical reconditioning. Following the original directive establishing the principle of reconditioning, other directives setting forth the details of operation and the importance of reconditioning in the overall mission of the Medical Department have been issued. Notably among these are S.G.O. Circular Letter #168, 11 September 1943, memorandum of The Surgeon General for Commanding Officers of General Hospitals, November 1943, subject: Reconditioning in Army Hospitals, and ASF Circular #73, 11 March 1944, which set forth quite in detail a sort of guide by which we feel that hospitals could really get hold of this thing and begin to function. In order to give further stimulus to this, The Surgeon General himself prepared a directive for Service Commands and Commanding Officers of General and Station Hospitals, which was sent out on 10 December, subject: Reconditioning Program. May I suggest that if you are not already personally acquainted with these directives you make it a point to familiarize yourself with them, at the earliest practicable date.

With experience and further observation the soundness of the program has become apparent to all. By carefully directed physical activity the actual time in hospitals for a given condition is actually reduced and upon discharge the individual is in far better condition to resume his accustomed duties in his unit or to take his place in war work or in civil life. With a well directed educational program his military objective is maintained and his time away from training is not wholly lost. Incidentally the need for sick leave is largely eliminated. I feel that under present military conditions as opposed to conditions in civil life many of our men suffer deterioration as a result of going home on furlough. I do not mean to say that we shall not give them a furlough but to let them go home when they are not able to go to duty, they become the hero of their family. They are surrounded, infiltrated you might say, with sympathy and they find out what is going on back home in the way of easy jobs and big money and it takes a man with pretty stalwart mentality to think these things over and not to wonder if there isn't some other person in the Army who could fill his job just as well. With this reconditioning we find we interest the man himself and they feel satisfied to spend their time recuperating in constructive reconditioning, whereas before the only thing to do was let them leave the hospital and to go home.

The Chief of Staff and the Commanding General of the Army Service Forces recognize the importance of reconditioning as a function of Army hospitals. Along with the Assistant Chiefs of Staff, G-1 and G-3, they have rendered every possible assistance in setting up the program in a comprehensive fashion. The Military Personnel Division, Army Service Forces, has authorized allotments of personnel over and above current personnel ceilings to cover the needs, and the Adjutant General is assisting in the selection of personnel especially fitted for the task. The Morale Services and Special Services Divisions of the Army Service Forces are cooperating in the selection, training and assignment of officers qualified to carry on educational reconditioning.

A plan is now under development through which it is anticipated the current shortage of occupational therapy aides will be met. The assignment to advanced reconditioning sections of line officers of company grade who have been reclassified for limited service because of battle wounds and who have outstanding qualifications of leadership has been authorized by ASF Circular No. 30 of the current series. Allotments of non-commissioned grades have been set up to provide appropriate rank and compensation for qualified physical education technicians. Furthermore it has been directed that these men qualified in physical training will not be removed from hospital assignments to fill quotas of general service personnel for duty overseas or elsewhere. A liberal policy has been established to permit the acquisition of supplementary reconditioning facilities such as C.C.C. camps, resort sites, club houses, etc. Necessary items of occupational therapy, gymnastic, athletic

and military training equipment have been authorized.

With the intense interest and active cooperation that is being evidenced by all concerned, the Medical Department is being afforded an opportunity to make another contribution to the war effort. The Surgeon General is determined that the Medical Department shall fulfill its responsibilities to the end that the reconditioning program shall grow rapidly to full fruition.

COLONEL THORNDIKE:

General Collins, Colonel Jones, Conferees, I would like to say, I feel that this group should be congratulated on gathering so many to attend. I believe that without the Commanding Officers of the hospitals and all those concerned with reconditioning that we cannot reach the particular personnel we would like to, concerning developments.

Reconditioning is new; it is subject to change, I mean certain things we said at the last meeting we will expand this time and at the meeting of the First, Second, and Third Service Commands possibly more will be added.

We have not as yet been able to get authority to publish our monthly news letter to get out to you but as long as transactions are reported we will send copies of each conference to all Hospital Commanders and all Service Commands, on the objectives of the reconditioning program in Army Service Forces hospitals.

This conference is assembled with one main objective, namely to clarify and implement the directives pertaining to Patient Reconditioning in fixed hospitals of the Medical Department of the United States Army. There is no more urgent problem than this program and its predetermined and expected results in salvage and utilization of military personnel. No longer is it possible to delay, to hesitate, or to waver over the utilization of military manpower. Again and again it has been emphasized erroneously that Army personnel can be readily replaced with civilians not yet called for induction.

It is perhaps indicated now to reveal to the members of this conference, the actual situation relative to future civilian manpower available for general military service. It was my good fortune when recently assigned on temporary duty with the First Service Command, to learn of the situation from a member of the draft board of one of our typical smaller industrial cities of that region. The statistics are most revealing. Many of us are not cognizant of the facts! It was most enlightening to learn that 91.5% of 1-A's have already been inducted; it was further of great interest to learn that the remaining 8.5% would be called in the next four months; and even of greater significance was the fact that, if all remaining classes are again reclassified, not more than 4% could be accepted from among those remaining and now classed as occupationally deferred for essential industry. The Army is confronted with a real problem; the Medical Department has accepted the challenge to provide a plan for salvage among patient personnel, and the Surgeon General expects results.

The Commanding General, ASF, has directed through Circular 73, 1944, that reconditioning shall be a Medical Department responsibility; has provided a means of obtaining adequate personnel

above present personnel ceiling allotments in each Service Command; and has directed the Commanding General of each Service Command to set up in each headquarters a staff to carry out patient reconditioning in all ASF hospitals. Even more significant is the War Department General Staff's approval of the increase in ASF personnel of four thousand three hundred over and above its current allotment; all this allotment constitutes trained personnel for patient reconditioning.

It is my duty to inform this conference that there is an extreme urgency to select and train this personnel at once and furthermore to assign it properly within each Service Command. Schools in orientation and education for officer and enlisted personnel have been established at The School for Special Services, Lexington, Virginia; a school in physical reconditioning for officer personnel is to be established there shortly; and the school in physical education and training for enlisted personnel at Camp Grant is awaiting student personnel. Qualified occupational therapists will be assigned as rapidly as graduated and made available. Thus, qualified personnel will be made available. It is advisable to train more than the number required, for obviously, some of this personnel will be required for patient reconditioning in overseas theaters. Your attention is directed to paragraph five (5) ASF Circular 73, 1944. This circular was published thirty days ago; the response has not been wholehearted. Nothing but a superior effort can place this program in effect promptly! The War Department so desires! Manpower demands require that hospitals will immediately develop this program to maximum efficiency in order that military personnel be maintained on active duty in utmost capacity.

The statistical division of the Surgeon General's Office informed me that as recently as the 11th of March, General Hospital Commanders at that time had granted convalescent furloughs and sick leaves to over eight thousand patients. This number of individuals on leave or furlough certainly prolongs the percentage of non-effectives in any Command. This conference is presented with this picture purely for consideration and in anticipation that the overall picture of non-effective strength in field units will be improved.

The objectives of patient reconditioning are clearly enunciated in ASF Circular 73. The program has been coordinated so that the soldier patient on discharge from hospitals will be better physically developed and coordinated, better educated, better oriented and informed, better indoctrinated, in fact a better soldier than when he was admitted. As a result of efficient compliance with the training schedule the number of soldiers returned to general service or special service will be increased, and the number discharged by certificates of disability will be reduced. The period of hospitalization should be reduced, and furthermore, the patient will be greatly benefited. The aim will be true; it is accurately computed to functionally restore the mind and body, and when

necessary restore the will to serve.

There is but one way such a result can be obtained, namely, coordination of a program. Physical reconditioning, educational reconditioning, occupational therapy, and diversional and recreational activities must dove-tail into a balanced program. Until recently, emphasis on this program has been too greatly focused on the physical aspects of the program. To be sure, this is important but no one phase of the program should be overemphasized at the sacrifice of the other. It would be just as great an error to have too great emphasis on diversional activities and recreation to the detriment of physical conditioning. Military training cannot be neglected at the expense of concentration in educational reconditioning or the academic study of arts and sciences. Sample well-balanced programs have been distributed to all Reconditioning Directors of Service Commands.

A program in itself is insufficient to produce the objective. There must be well qualified personnel and there must be equipment and supplies. Such a combination cannot fail but produce the desired results. The objectives are clear; the tools are at hand. It is our duty to produce the results desired by the War Department.

In conclusion I quote from an editorial in the Journal, American Medical Association of 1st April issue 1944:

> "Here is a challenge to the Medical Profession to restore as many of the nation's sick and wounded soldiers to duty as early as possible. Sound practical plans including competent personnel and adequate materials have been authorized. The ultimate success of the plan, however, rests with the individual medical officer, whose judgment in each soldier's welfare should rest on accepted scientific principles."

The challenge to every medical officer has been announced! The urgency of establishing the objectives in the Patient Reconditioning Program is paramount! The success of the program can be appraised only by its results! To each Service Command, to each hospital commander and to all concerned, I announce that the Surgeon General awaits your results.

GENERAL COLLINS:

Colonel Jones and Conferees, I want to first welcome all those who came from beyond the borders of the 5th Service Command to attend this Conference. What I have to say this morning will be from the standpoint of a layman. I have no prepared speech. I am just going to ramble on, making some observations on the Reconditioning Program as I see it. I don't think there is anything more important before the Army today than to work out and put into effect as soon as practicable, the Reconditioning Program. If we fail in this War today, or rather our failure to date, can be measured by our failure to prepare our people psychologically for this war. The morale factors to the physical, I would say, are from three to ten, to one. That applies for the fighting on the battlefield or reconditioning the man after he is wounded. The thing it is going to take is interest; every man has got to feel that this thing is necessary, is important, and put everything that he has into it. You have to select your men on that basis. As I understand the situation, patients in the hospital may be divided into four broad classes, and this reconditioning will begin, with those in the fourth class, going on into those in the first class.

For myself, visiting around the hospital, I believe the biggest problem that you are going to have is to get the men who come back from Overseas, the wounded men, in a frame of mind to want to be reconditioned. A great many that I have talked to have the attitude, "I have done my bit, now let the other fellow get over there and do a little fighting". That is a bad condition. It is something that we have to go after. The approach, as I see it, is morale and psychology or whatever the technical term is. The approach, as I see it, if you once get the man in the proper frame of mind the rest will be easy. Your physical training will have to be intensely interesting in order to put it over. I remember years ago; you probably knew the man at West Point--the Director of Physical Training there. That man, in my opinion, did more in the U. S. Army to build up the physical condition of the Officers than any man we have had. He tried to teach them the sound problems of physical training. He was a marvelous man. When he got up to talk before a group, everybody was lifted by his very presence and approach to the problem. I think that we have to select, and I assure you that we will give you, the best available for those purposes.

I think also that your reconditioning cannot start too soon. When I inspected down at Greenbriar, the next day while inspecting a Prisoner of War Camp, in talking with a Prisoner of War, I noticed little looms that the men had by their beds. The next day one of them sent me a loom he had made. There were 50 or 60 at the hospital that the men had made and worked with their hands. I have a very close friend, a Medical Officer, in Denver. He is very ill and he has had one of his lungs collapsed.

He is working along that line. So I say, the way it looks today, as a layman, the whole approach to the thing is to get the men in a frame of mind so that they want to get well and go back to duty. I have played polo all my life--I broke my arm and nearly broke my neck a couple of times. Doctors told me that I would never have complete use of my right arm; I decided I would have complete use of my right arm, but it has taken will-power, and that is one thing that you must instill in these wounded men, that they will be just as good or better. Then they will try much harder, after that, to put over that idea. It takes enthusiasm to do those things. Again I say, gentlemen, I am talking from the standpoint of a layman. Anything that I can do personally, or my staff can do to back this thing up, we are behind it to the limit. It is one of the most important programs in our country, and when casualties begin pouring in from Overseas, as they will in the not too distant future, this program will be of tremendous importance. Thank you.

COLONEL BLAKELY:

General Collins, Friends of the Conference, General Porter asked me to express personally his regrets in not being present at the conference, as he is vitally interested in the type work that is being carried on in these Reconditioning Centers. The importance of reconditioning of these valuable men that General Collins has just told you about cannot be over-emphasized when you consider it in the light of conserving our trained personnel. That was the subject assigned to me. I got it Saturday. I would like to say that the War Department G-3 Division is back of you 100% in your work and we will do all that we can to assist you in every way possible. You will probably feel the need for certain training aides. That will always come up in training. Never take no for an answer. General Collins said he would back you up. We will do the same thing. If you need something in a training aide capacity keep asking until your request reaches the War Department and you will get action, so do not take no for an answer. The attitude of our division in Washington on this Reconditioning Program was very clearly set forth by General Porter at Schick General Hospital on 21-22 March. I know most of you have read the report of that conference. If you have not, I think you should. It was very enlightening to me to know what was going on in these Reconditioning Centers. I would like to remind you here that some of the remarks I have to make must be considered as of a confidential nature.

General Collins just told you that mental reconditioning was the first step. I agree with him in this mental reconditioning. These men do feel that they have done their bit and the remarks that you hear from them at times cannot be repeated. That man is potentially very valuable to the service. He is a replacement somewhere. He must be used, he must be reclaimed. Now you must put him in that mental attitude that I want to go back and fight again. Those men over there are taking it, have been taking it, some of you know, some of you have been there. They are really getting out of the hospital as soon as they can and getting back to their units. It is hard to get a man from the hospital over there to go to a Rehabilitation center, as it is known, for he feels he will not get back to his unit with his buddies. A lot go AWOL and go back to their units. They do not report these cases, they will turn up in two weeks and so Private John Doe is back with his unit. He is marked off the list not as AWOL but as a fighting man. The conservation of trained personnel is of vital importance to our division. As you already know we have reached our peak of 7 million 7 hundred thousand, and every one of these men have been assigned to a specific place; they have a specific duty to perform. If we move one of them we have to replace them from another place. The future does not present a very bright picture for getting more of them, consequently, every man that you can return to duty from you reconditioning program is vital to this manpower situation. A thousand men reconditioned today represents several thousand in

the eyes of the War Department a few months ago, it is that critical. Therefore, it is up to you here and in the other reconditioning centers to turn out as many men as rapidly as you can now to assist in this speed-up. It is felt that some thought should be given to the possibility of getting these men away from the idea of being patients as soon as you possibly can. This can be accomplished if you establish a training area away from your hospital. General Sawbridge, G-1, North African Theater, recently in Washington, made the statement that they had found by practical experience they could return wounded men much faster to duty by separating them into training areas apart from the hospital for reconditioning. Now, that is an actual case in a theater of operation, where they have found this to be true. If it is true there, it can be true here. If you are already doing it, in reconditioning centers, you should give a lot of thought to using your officers and your non-commissioned officers that are patients as your instructors. These are valuable men, they have had actual battle experience which helps them to recondition other patients.

General Porter observed one officer giving instructions at Schick General Hospital. He was using plain old language, "we would do this in this situation", or "in this situation I would do this!" That brings back to those men the fact that he knows what he is talking about. They make valuable instructors; the men will listen far more to them. General Hillman said you were going to get limited service people as your instructors. How long before they will come to you is another question - I think they will send them to you as soon as possible. Even in our present need for the conservation of trained men, it has been found necessary to increase the strength of some of our branches in order to take care of future possibilities, such as: increase in our bomber program; increase in our artillery; support for ground troops; increase in our service troops, that is, the Army Service Forces. Now, those men must come from some other place. You will also have an increase in service troops, to support the program I have given and increase in the replacement requirement due to battle experience. Heretofore, these replacements have increased, as we have established a rotational pool. They must come from somewhere to replace those men at the battle front. This has of necessity required us to reduce and readjust our manpower. This reduction has been met in several ways: We have reduced the Army Specialized Training Program; we have found it necessary to curtail tasks imposed on post commanders; we have found it necessary to abandon small posts which are uneconomical in the use of manpower.

These steps were taken because since July 1943 we have consistently had a deficit in inductees with the quotas as requested to meet our anticipated needs. Selective service will furnish only

sufficient men to meet replacement needs. The fillers must largely come from recovery processes, and that is one of your jobs here to recondition and return these valuable men to the service, as soon as possible. You have here some of the cream of our fighting men who have already been trained and have had the experience that we need vitally now as potential leaders. The War Department feels very keenly about reconditioning these men, to refill our slowly draining bucket of reserve manpower. It has been found necessary, at times, to inactivate units in order to constitute a new type unit. Now when we constitute a new type unit which was inactivated from another unit, you have reduced your reserve. Now we cannot reduce that reserve too much, we must have something to back up this reduction. These men you recondition in these centers will fill that place. In order to conserve our trained personnel, the War Department has established three personnel reassignment centers as follows: Camp Butner, N. C., Fort Sam Houston, Texas, and Camp White, Oregon. These centers receive, classify, evaluate, and recommend reassignment of personnel made surplus through reduction of overhead or in activation of units. When you inactivate a unit to constitute a new type unit, you will have some overhead. That personnel that is left over is sent to one of these reassignment centers and there reassigned to another job. Battle casualties (less Air) capable of performing useful service not in arm or service to which currently assigned are sent to these centers and they find a niche somewhere in the army for that man. There are many other types of men in the army who could be reassigned to a niche they can fill. Furthermore, it has been found necessary to screen thoroughly men classified as of no further value in the combat theater, prior to having these men returned to the United States. In one example, one theater wanted to send back several thousand men, they were authorized to send back some of them. In reclassifying, checking and evaluating these men, they found that some fifty percent were capable of some combat duty.

The situation is critical in manpower and we must face that fact and we must do all we can to rebuild these men you have here and to build our reserve again.

We are now preparing in our division and in the Army Service Forces for reconditioning in the European Theater. We want to reclaim and train as many of those trained soldiers as we can.

I have only attempted to cover a few of the important points on the conservation and the reasons why it is necessary; there are many more, I could talk for a long time about them.

In conclusion, I wish to re-emphasize the importance of the work here and to say that our Division in the War Department is very much concerned in this process of reconditioning of valuable men for our waning manpower reserve.

LT COLONEL SNELLING:

General Collins, Colonel Jones and Conferees: I am going to talk on the subject from a practical point of view - from observations we have made here at Nichols, and we feel that we have cultivated a public relations set-up in Louisville and this vicinity which we believe will compare favorably with any cross section set-up in the country.

First of all, we have been called on, on numerous occasions, to let these people know what a general hospital was; what its function was; what its organization was, and, realizing that they are vitally interested in a general hospital, we have laid that ground work. We have noticed in recent months, in the last 2 or 3 months, they have a very good understanding of this general hospital; the public has become very vitally interested in what we are doing for the returned soldier - for the sick and wounded soldier - in addition to the therapy - in addition to definite treatment.

We feel that it is of vital importance that the public should be informed of this Reconditioning Program. We have found that the people of this city are calling on us all the time and when they ask to have a speaker, they ask that he speak on the subject of Reconditioning. They have gotten the idea of Reconditioning; it is growing, it is developing all the time; and they ask that the subject covered be on that line. It isn't always specific, but it comers some phase of it. Of course, they have been told before this of the different specialized hospital centers that the Army has. They were vitally interested in the fact that we took care of the blind, crippled, deaf cases, etc; that has been covered. That is a phase they now thoroughly understand. The Reconditioning Program is the one we are now stressing.

We feel that it is vital that the mothers who represent the real force in the public - that is, not the entire real force, but certainly one of the greatest parts of the force of public opinion- the mothers of these boys, if they are well informed as to what this Reconditioning Program is, if they are well informed as to its vital necessity, can do a great deal towards building the soldiers' morale; they can understand better why that man is not allowed to come home and stay around the house for days on furlough, and they can understand that when they do see him, they can talk intelligently on the subject and further boost him.

I think we are all agreed that the lay public can do either one of two things: It can either break down the soldier's morale, or boost it and help to keep it at a higher level, particularly in these men we are trying to mentally and physically recondition. It is important that the public take that point of view, and exert its influence in that direction. The boosting value that they can have we feel will pay large dividends. There are ample opportunities to present this, and we have done so by thorough cooperation on the part of the Courier-Journal and Louisville Times. We have contacts

with radio stations and we have been given on innumerable occasions opportunities to contact womens' clubs and civic clubs in this community. I think the same thing - in fact, we know those same facilities in toto, or some of them, exist in all of the communities where our hospitals are located, and we don't feel we can overemphasize selling this program and a full understanding of it to the public.

CAPTAIN SILVERMAN:

General Collins, Colonel Jones and Conferees:

We, here at Nichols General Hospital, have long realized that the over-all discharge rate for psychoneurosis has been very high, and also that this condition has constituted a significant source of lost man power. This led to our adoption of a technique for salvaging these patients which involved the following triad of procedures:

1. Early diagnosis

2. Intensive specific treatment-psycho-therapy

3. Exposure to a reconditioning program as soon as feasible.

Speed in preparing the neurotic patient for reconditioning is of utmost importance. This is especially true in those cases which have had repeated hospitalizations overseas or in the Zone of Interior, with resultant tendencies toward chronicity and fixation of symptoms and habituation to a sheltered and protected environment.

Frequently, psychoneurotic patients can begin to participate in the reconditioning program after only a few psychotherapeutic interviews. Psychotherapy is then continued as part of re-conditioning. This procedure can be used with battle casualties whose symptoms are of relatively short duration, and whose personality make-up was stable prior to exposure to unusual stress and strain during combat. In these cases, exogenic situational factors have been the immediate cause of breakdown. We might say the environment has been sick rather than the individual.

In other instances where deep seated and long standing powerful unconscious forces are responsible for the smyptomatology, more prolonged psychotherapy is necessary before exposing the patient to reconditioning. In such cases the neurotic illness, until it is well under control, will act as a Fifth Columnist, to sabotage all the possible benefits that a reconditioning program might offer. These patients will not be able to utilize the advantages of such a program no matter how badly they are in need of them or want them, until they are actually on the way to mental health.

Patients are seen by the ward officer within a very short time after their admission to the Neuropsychiatric Ward. The initial interview that is held is the foundation on which all subsequent treatment is built, and on which successful reconditioning may

depend. It is at this time that feelings of dependency and attention gaining mechanisms which hospital atmosphere engenders, especially in neurotic patients, are nipped in the bud or neutralized as much as possible. It is impressed on the individual that though he is a patient, military conduct and discipline will be maintained at all times. Rapport, stimulation of confidence in recovery, and orientation regarding treatment and reconditioning, are all stressed in this highly important first interview. Each neurotic patient is given a minimum of six hours of psychotherapy, either in the form of individual therapeutic conferences or by group therapy methods. Suggestion, reassurance, hypnosis, and sodium amytal narcosis are the various techniques employed. Careful planning of available time is necessary in order to give each individual as much specific therapy as possible. When the patient population is high, and the amount of time available for each individual necessarily limited, group psychotherapy is of great value. Furthermore, by this technique it is possible to demonstrate to the patient the way in which neurotic behaviour results in poor morale, inefficiency and unhappiness, not only for himself but also for a group—not only for one person, but for a community. In this way, neurosis is shown to be worthy not only of individual attention but also of group study and attack.

This common danger—neurosis—and concommitantly the common aim, its eradication, makes for better discipline in the patient group. Thus psychotherapy is the core around which N-P reconditioning at this hospital is built. This in no way, however, minimizes the valuable and necessary assistance which is afforded by drug therapy, physiotherapy and supplementary programs for occupational therapy, orientation, morale, education in military and non-military subjects, and recreation. Occupational therapy is always planned in detail to fit the interests, background and emotional status of the neurotic patient. It is literally prescribed for him, just as if it were a prescription for medicine. Morale is highly stressed. My contact with psychoneurotic soldiers reveals that a highly significant contributory factor leading to their breakdown has been a lack of understanding or distorted viewpoint regarding the issues of this war. Many have undemocratic, un-American ideas, and consequently, have had no incentive to submerge their own problems and differences of opinion to the major task of winning the war.

The general management of psychoneurotics, as well as their reconditioning, must be carried out whenever possible by personnel who are competent to deal with the special problems involved in handling such cases. Ward personnel and reconditioning personnel are continually being trained with this purpose in mind. Through close coordination between the reconditioning officer and the neuropsychiatrist, men are especially selected and assigned to

help conduct and carry out the various parts of the reconditioning program. They must at all times have tact, sympathy--sympathy in the right amount, and a general understanding of the emotional make-up of neurotic patients in order that maximum efficiency and most beneficial results in reconditioning be obtained.

LT. COLONEL HILTON:

General Collins, Colonel Jones, Conferees: As indicated to you, I am going to conduct my talk to you on the subject of Reconditioning from the viewpoint of the Patient Officer. This talk will be primarily my own personal observations and opinions. In fact, it is purely from the layman's standpoint.

As you probably know, the supervision of the Reconditioning Program in this hospital is conducted by the Patient Officers; that is their part in the Recondition Program - to use them in their normal command capacity, as officers. Without this officer personnel, such an ambitious program cannot, in my opinion, be put over, other than by augmenting the hospital staff with a large administrative group. And, as I mentioned before, this Program is for reconditioning of officers also, so, on that basis, let's put them to work.

I appreciate that this Program is in its infancy as far as actual operation is concerned. Already we have bumped into many problems, most of them unforeseen and throughout the Program, we have tried to use the cut-and-try method, but up until this time, it is the only method feasible to show what could or could not be done. To make a successful go of the Program, everyone - and I repeat everyone, must be sold on it personally. They must be sold on it. This means the hospital personnel as well as patient personnel - both the Officer Patients and the patients who are receiving the reconditioning. If everybody isn't sold on it, friction is bound to appear between the Patient Officer and the hospital group. That is the first on the "must list" - the indoctrination of the hospital group.

Second on the "must list" is the indoctrination of the officer patients who have been selected. They also must be thoroughly sold on the program.

Thirdly on the "must list" is the selection and assignment of officer patients to wards. The supervisor or the head of the Reconditioning Service should be consulted on this and advised as to when the officer will be available and as to the proper length of time he will be in the hospital. As far as possible, the officers who are to remain for a reasonable length of time should definitely be assigned as training officers to the wards, assuming, of course, they are satisfactory in other respects. Once again, one has to use the cut-and-try method, simply because the supervisor or hospital group is not acquainted with the patient officer and you will find, as we did here, that some patient officers are apt to assay rather high in gold. I speak from a "brick" standpoint when I say that. On the other hand, simply because some individual is commissioned does not mean he is a combination of teacher, psychologist, leader, and instructor all rolled into one. All of us at some time have had this same situation. Try and get the man who is really sold on the program and who indicates some enthusiasm to

make a go of it. You will have to have this enthusiasm if you are going to make this thing click. I know that some of you are probably thinking that the officer can be ordered to make a success of this program. Maybe he can be ordered to, but if the opportunity is presented to select an individual who you believe will make a go of it simply because it's a job and who is the type of officer who likes to see things work out in the right way, you've won half the battle right there, particularly when we are in the guinea pig stage of this program.

This doesn't mean that the other officers can sit back as there are plenty of jobs to go around - they can be assigned as assistant training officers. Or some may be excellent instructors on shop subjects and not so good on academic subjects. Then there are the occupational subjects that officers are specialists is, such as law, automobile repairing, agriculture, physical conditioning, physical training, animal husbandry, or even an instructor for the gardening group, which we have here. I'm sure there is a place for all without too much crowding.

Now, if possible, two training officers should be assigned to each ward in that the officers themselves are required to report for various of the hospital functions, such as dental and X-ray clinics, physio-therapy, etc. These appointments can usually be staggered so one officer is on the ward at all times during the normal reconditioning hours. It would be ovey better if three officers could be assigned to each ward, the so-called surplus to act as a pool and to take over a ward when the regularly-assigned officer is either transferred or discharged.

The next item on our "must list" is the interviewing of each individual patient. Common sense, or a bit of psychology, will have to be used on this interview. The applicant should be steered toward the ultimate which he is apparentlycapable of absorbing. Do not do as we had one applicant do - where the applicant had six or seven years of grade schooling, he put in his application and wanted to take up the Chinese language. That, obviously, would not work out. Get the applicant within the sphere of his capabilities. This is important! Some can take certain subjects, while others over-estimate their ability. You will have to watch this. Once again, the teaching ability of Patient Officers comes to the fore. Use common sense - let's not try to do the impossible. I am glad to say that most of the subjects are greeted with considerable enthusiasm by the patients who are happy to be instructed in the simple art of reading and writing. It is rather hard to visualize that in this country of ours, some men cannot read or write. In fact, we have one individual who has been in the Army, has been at Guadalcanal, was wounded and is back here, and cannot read or write. It is our job to recondition him. On the other hand, we have one individual who will receive enough credits through the Army Extension Courses to get his BS degree from the University of Kentucky within a few

months. I freely admit that these two cases are extremes, but it gives you a small idea of the educational scope of the program. Again I wish to emphasize the proper selection of Officer Patient personnel.

One other item on this self-study arrangement. Have the necessary material on hand for each subject. Again, we become guinea pigs on that and you should be able to gain considerable experience from the Program we have initiated here. Make sure you have the necessary material on hand for each subject on the prescribed list. Don't let the applicant down. It is far better to say that you can't furnish the individual the necessary material on certain subjects than to have them submit an application and then find out the required material is not available. This is another "must".

The Form A - interview sheet - and the progress chart indicating the applicant's ability are in each ward. We invite you to look them over when you make a tour of the hospital.

The progress chart, the exercise card, and the duplicate copy of the Form A should accompany the patient when he is transferred from one ward to another. It should be a part of the patient's medical chart - this is just another indication of the necessary tie-in between the training officer and the hospital personnel. Again, the necessary indoctrination of the hospital group and the patient officer group comes to the fore.

As I said in the beginning, this is an ambitious program; it can work and it will work. It has worked out here. You can appreciate this when you realize the fact that a fair portion of the patient personnel started on the program possibly were barely able to lift their heads from the pillow, and are now in shops or schools or taking some sort of self-study or exercise. It enables each patient to get his mind away from his injury or sickness; it strengthens his body and, finally, it assists him either to return later to a place in civilian life or -- what is more important -- to continue his function as a member of the Armed Forces.

In summing this up, please remember these are my personal opinions and observations:

1. Thorough indoctrination of the hospital personnel.
2. Thorough indoctrination of officer patients and enlisted personnel.
3. Selection and assignment of officer patients to the wards. You must use judgment.
4. Interview and assignment of self-study material to patients.
5. The proper coordination of the physical and orientation programs.

COLONEL JONES:

How important this program is and in making the plan work, how everybody from the lowest to the highest are behind it. We hoped to have Major General Joe N. Dalton, Director of Personnel present. In reply to his invitation, he wrote General Collins the following letter:

"This will acknowledge your letter of 30 March 1944, in which you invite me to attend the Reconditioning Program Conference to be held at Nichols General Hospital on 10 and 11 April.

"I have been following very closely the progress of the Reconditioning Program and would like very much to attend your Conference; however, I have been committed for some time to a visit which will take me into the Fourth Service Command through 12 April.

"Colonel John W. Childs, GSC, Chief of the Management and Separations Branch of our Military Personnel Division will attend as my representative. Colonel Childs would prefer accommodations at Nichols General Hospital.

"With very best wishes and personal regards, I am

Sincerely,

/s/ JOE N. DALTON;
Major General, G.S.C.
Director of Personnel

I thank you.

COLONEL JOHN W. CHILDS:

As has been indicated, General Dalton regrets very greatly his inability to be present at this Conference. General Dalton, as well as others, is fully aware of the great responsibility and the possibilities of this Program. I know of no other single project that has the possibilities or that has the appeal that this program has - the appeal to the individual soldier, the appeal to the Army and the appeal to the American people as a whole.

I do not propose to give you any personnel "musts" in this program I come rather to gain a first-hand experience or first-hand knowledge of your problems, and to take these problems back and to assure you that the Personnel Division will cooperate with you in every way in accomplishing the success of your program.

I thank you.

Dr. C. H. McCLOY:

The importance of the physical reconditioning program.

The medical profession has always been quick to avail itself of new and effective means of treating a patient. This is illustrated at present by the extensive use of the sulpha drugs, and by the utilization in the Army Hospitals of all the best information being accumulated in the fields of surgery, of neuropsychiatry, and of medicine. The physical reconditioning program is another such effective method of treatment. In this case it is directed, not only at quick recovery from a disease or disability, but at implementing quick recovery to normal duty status which, for the Army, is almost as important at the present time as quick recovery from the disability. It is important that the patient shall not slip back in physical condition more than is necessary while he is a hospital patient. He should, if possible, maintain his full physical capacities. He should make progress as rapidly as possible. Many patients coming to the hospital were not in good physical condition when they were incapacitated. Many come almost directly from civilian life, others come from units of the Army which are not as well conditioned as are other units. It is the responsibility of the Medical Department to put them in as good condition as is possible before they report again for duty.

This type of exercise program does definitely speed recovery itself. Hence, we feel confident that the surgeons of the Service Forces will avail themselves of this method of treatment as fully as possible.

To insure that the patient will improve in physical condition and not retrogress, the dosage of exercise must be at least up to the normal to which he is accustomed. The human organism tends to adapt itself quickly to the demand made. If the demand is less than his accustomed demand, the organism gradually deteriorates and his muscles undergo partial atrophy. If, however, the demand is in excess of the load that he has been carrying normally, the organism adapts by hypertrophy of the muscle and improvement of its quality. For example, a man whose arm is strong enough to handle a forty pound dumbbell may exercise to excess with a one pound dumbbell with no appreciable increase in the strength of his arm, because his arm is already strong enough to handle a one pound dumbbell with great ease. If, however, he were to exercise with a forty pound dumbbell for a few days until he gained more strength, and then to use a forty-five pound dumbbell and then a fifty pound dumbbell, and so on, his strength would increase very rapidly. The same is true of endurance. A normal individual who exercises to the point of respiratory and cardiac distress, as is the case with distance running, or sprint running up to distances of a quarter or half a mile, will rapidly improve his performance and endurance.

Strength is of considerable importance to the soldier. A soldier has to carry loads considerably greater than the loads carried when he was in civilian life, hence strength needs to be increased up to about twenty-five to thirty percent more than is normal for a civilian. It is important in the Reconditioning Program, therefore, that considerable attention be given to the development of muscular strength.

Another important element is what is called muscular endurance. That is the ability to carry a moderate load over a long period of time. This may be thought of also as the development of stamina. In submaximal exercise of muscle groups carried over a considerable period of time, there is a pyperplasia of new capillaries into the muscular tissue. It has been found by physiological research, notably the work of Krogh, that the actual number of functioning capillaries may increase as much as four hundred percent in active working muscle tissues. In six or eight weeks of inactivity, these become non-functioning again. Hence, it is important that exercise be continued in hospital as a maintenance measure.

Another element of importance is the development of cardio-respiratory endurance. This is frequently spoken of as "wind". In the development of this type of endurance, the heart is the principal organ. The heart, is indeed, the chief respiratory organ, as it determines the amount of blood which actually reaches the muscles, and other tissue, and, therefore, determines the amount of oxygen reaching these organs. The exercised heart does not necessarily develop to an excessive size; the heart of the marathon runner is usually only average in size. It does, however, have a very rich capillary supply.

The chief improvement seems to be an improvement in the coronary circulation, together with the development of a rich bed of capillaries. Conditioning of the heart itself is complicated, but the result of which is to produce an efficient cardiac output.

This principle of working the various muscular organs of the body to what might be termed excess (in relation to an individual's normal functioning) is spoken of by physiologists as the "overload" principle. It is not an "overload" in the sense of a load that breaks the body down, but a load over that normally carried. The individual needs to push himself to local, and to a certain extent, general distress. This is, of course, relative to his condition at the moment.

The increase in dosage of an exercise program should be gradual, especially with a class 3 patient. For example, in recovering from pneumonia, the exercise on the first day after he has been assigned to the exercise program by his medical officer, will be very mild indeed. A double or triple amount, however, may be given

the second day, and still more the third day, provided the ward officer so prescribes. In the conditioning of the normal trainee, the exercise increase may be from ten to fifteen percent each day over the ordinary period of training, up to four or five weeks. It is important that this not be overdone at first. When an individual exercises to excess, it has been learned that there tends to be an inhibition to the output of the secretion of the cortex of the adrenal glands. This results in a feeling of prostration or, at least, of a great lack of energy. It has also been found that exercise within the normal limits, pushed a bit over what has been customary in the past, results in stimilus to the output of cortin, giving an increase in available energy.

The medical officers should consider the difference between a program of maintenance, and a program of improvement. First, when a patient goes to the hospital, especially when he is immobilized for sometime, he tends to retrogress rather rapidly. A patient in excellent condition retrogresses even more rapidly. It has been found by experimentation in the physiological laboratory, that an individual capable of enduring 18,000 kilogram meters of work in a given time, without rest, after two weeks inactivity in which time he is walking around but doing no other exercise, will retrogress until he has the ability to do only 8,000 kilogram meters of work in that time. Hence, it is important not to let up on the program.

In such instances as an operation for the removal of a cartilage in the knee, that leg is usually immobilized for a number of days. In order to prevent the muscles from deteriorating rapidly, the surgeon usually resorts to what is called "quadriceps setting". This, however, is frequently a very light type of exercise, and involves only a mild twitching of the patella. This will not be sufficiently strenuous to retard atrophy to any great extent. This type of exercise can be made much more strenuous when the knee will permit it, by contracting the quadriceps against the resistance of the hamstrings. This may then be made as strenuous as is desired.

The lymph is kept moving by even mild muscular exercise. It will be remembered that the lymph is the fluid which actually surrounds the cells. The blood brings food and oxygen to the lymph, not directly to the cell, and by osmotic pressure, this is moved into the cell and the cell wastes are returned to the lymph, and then into the blood. The maintenance of a normal circulation rate in the lymph stream as well as the blood stream is important.

Another rather important consideration, is that even mild exercise in bed, may possibly prevent the development of phlebitis. In hospitals where the patients are ambulatory relatively early, and where bed exercises are conducted, this complication is seldom present.

A hospital patient, particularly a surgical patient, is apt to seem to be much sicker than he is. This is largely due to emotional shock, and to mental suggestion. The average civilian going to the hospital for an operation, is frightened. If he is relatively ignorant of operative procedures, the whole process is rather mysterious and impressive to him. As soon as he comes out of the anesthetic, his family makes so much fuss over him that he not only thinks that he is ill, but rather enjoys it, and settles down to a period of contented convalescence. Some of this condition, however, is due to what might be termed "sympathetic shock". In this case the mental suggestion, together with some of the handling of the fiscera, and things of that type, tend to cause the splanchnic blood vessels to unduly dilate, with the result that the blood tends to lake in the splanchnic area. If the man arises from bed and stands by the bed, too much of the blood has accumulated in this area and there is not enough in the general circulation, so that gravity tends to pull too much of the blood from his brain, and he suffers a temporary brain anemia. This may even be sufficiently severe as to result in fainting. It may, however, simply make him dizzy, or cause him to be nauseated when he exercises. Two things need to be done. First - there needs to be some mental reconditioning. The whole atmosphere of the ward should be to the effect that he is not a sick man, he just happens to have had a cut made in him some place, but all the rest of him is still all right. There should be understanding, upon the part of the ward personnel, but not too much sympathy.

Second - since he has this condition of splanchnic dilatation, he can exercise in bed, where gravity is not pulling the blood from his brain, and undergo a considerable dosage of exercise without any nausea. Hence, even in class 3 patients who feel a bit wobbly, they should be first exercised in bed. If, for example, the individual does six or eight exercises in bed, usually the stimulus of the exercise has its normal effect of reducing the splanchnic dilatation, and the man can arise and begin to exercise more vigorously while standing. This can be readily experimented upon by any normal person who has lost several nights sleep. Usually, when such a person arises and begins to exercise he feels rather faint, or even nauseated. If he will first do three or four exercises in bed, including one in which he either raises his knees hard up against his abdomen, or sits up and lies back again fifteen or twenty times, he can then arise from bed and find that he is ready to continue his exercise without feeling undue fatigue, prostration, or dizziness. Because of these facts the individual patient who is exercising in bed can do a much more strenuous amount of exercise than he could, were he standing. First, he is not carrying the weight of his body, hence the exercise is more localized on the muscles actually engaged in that activity. Second, however, he is assured of a sufficient blood supply to the brain and medulla, so that he will not be subject to the

frequent feelings of exhaustion or nausea, from such an exercise.

Another thing to be called to attention is the fact that one part of the body may be exercised at a time. This is the case, for example, when the quadriceps is exercised in knee injuries. However, the same principle can be applied to the other parts of the body, exercising one arm at a time, or the chest muscles, or the shoulder retractors, or any one group. An individual, such as a medical patient recovering from hemorrhage from an ulcer, after the ulcer has had an opportunity to organize and there is no more occult bleeding, the individual may exercise one small part of the body at a time without either unduly raising the blood pressure, or increasing the pulse rate, thus enabling him to remain in much better muscular condition than is usually the case when he lies around the hospital for, perhaps several months.

There are several considerations which may well be given attention in connection with surgical patients. First the patient must have every procedure applied that will enable him to get well more rapidly. Exercise tends to increase the circulatory rate and to raise his metabolic rate so that there is more rapid healing of fractures, and of surgical wounds. This seems to carry over from exercised parts to non-exercised parts. For example: Two men with fractured tibia, who have their legs in casts, may pursue different procedures. One simply stays around the hospital. The other engages in a great amount of exercise for all parts except his broken leg. When the casts are removed, the leg of the first individual has atrophied markedly, that of the second individual has atrophied very little, and recovers very promptly.

An individual with an abdominal incision will recover much more rapidly if the other parts of the body are exercised, and his abdominal muscles do not deteriorate to the same extent.

There has been considerable experience associated with athletic teams accumulated by persons along lines of accelerating the recovery of many types of surgical disabilities. In such cases it is the desire of the surgeon to accelerate the recovery of the individual as rapidly as is consistent with his welfare. Frequently, in civilian life a sprained ankle will be immobilized for two or three weeks, when, if that ankle was attached to a valuable football player, it would be so treated that he would be playing the game again within a week, and with benefit to the ankle. It would be helpful to investigate what has been done along these lines. There are excellent publications which are available.

When a patient with an abdominal wound is permitted to get out of bed and become a class three patient, he should be instructed to carry his chest relatively high. Sir Arthur Keith, an eminent

British anatomist and anthropologist, some years ago experimented to determine the changes in intrapelvic pressure brought on by changes of posture. Sir Arthur introduced a rubber bladder into the rectum connected with a manometer on the outside of the patient, so that he could measure the intra-pelvic pressure. It was found that this intrapelvic pressure as much as tripled when changing from a good posture to a poor posture. This means that with the slumping posture of a flat chest and rounded back the intra-abdominal pressure tends to increase, and, at the same time, to increase the strain put upon any abdominal wound. The high chest carries the diaphragm upward and the air pressure on the outside of the abdomen presses the abdomen backward, so that the viscera rise in the abdominal cavity and bulging pressure from the inside on any wound is practically absent.

The patient with an abdominal operation should be instructed to keep the glottis open when doing all exercises. If he closes the glottis and "bears down" as he is wont to do, the intrathoracic and intra-abdominal pressures are increased considerably, adding strain to the wound. If he is instructed to keep on breathing, or to talk or count at the time he is doing the exercise, the glottis will remain open and the extra pressure from within will be avoided.

Another consideration has been brought to our attention by a British physician by the name of Passmore. Doctor Passmore called attention to the fact that intrapelvic and intra-abdominal viscera were under no particular strain from either exercise or from a slight jar. This may be illustrated in the following manner. If an egg is placed in a Mason jar and shaken, the egg will break. If, however, the jar is first filled with water before the cover is placed on, this may be shaken or thrown around without injury to the egg unless the jar is broken. In the abdominal cavity the various viscera, which are about 80% water, are floating in other viscera of approximately the same specific gravity. They are not shaking around in an open cavity. It is much the same situation one would find if he packed a vase in pillows in a trunk. The trunk could be quite roughly handled without injury to the vase. Hence in such operational procedures as involve a cutting of a fiscus inside, such as the removal of an appendix or an anastomosis of the small intestine - after two or three days, when there has been an opportunity for the beginning of primary healing, there is practically no danger of any dislocation or any injury to the viscera by reason of exercise.

When there has been an operation upon the trunk at anytime, until there has been ample time for healing, there should be very little exercise of the type which involves sudden and severe jars, such as jumping down from a seven foot wall of an obstacle course. This will result in a so-called"water hammer effect". For example, if one were to grasp the neck of a full rubber hot water bottle and swing the arm vigorously downward and stop the hand suddenly, there would be a probability of the neck of the water

bottle being torn away by the momentum of the weight of the water. This is the water hammer effect. This may happen when an individual jumps down from a height and stops the downward motion too quickly. Hence, this type of activity should be avoided in these cases.

In orthopedic cases there should, of course, be remedied exercise for the affected part. In spite of the fact that there is general exercise for the whole body, the part operated upon tends to relax or atrophy somewhat, as, at the beginning it is not possible to exercise with sufficient severity. Hence, when recovery has reached an appropriate point, various kinds of exercises are undertaken, starting with very gentle ones and slowly progressing to much more severe ones. These vary from the very gentle things prescribed for these parts with class 4 patients, up to the much more strenuous activities which would be undertaken by a class 1 patient almost ready for duty. These exercises are prescribed by the medical officer concerned and carried out by the non-commissioned personnel.

Many officers in the medical services of the hospitals have been loath to experiment with exercise in the reconditioning of medical cases. The facts have not been as clear cut as they are in the case of surgery. There has been in civilian practice almost no precedent. There has, however, been considerable experimentation in the Air Forces hospitals on medical diseases. A well conducted and long continued experiment at Jefferson Barracks, in Saint Louis, by Colonel Rusk and Captain Ericksen, on cases of a typical pneumonia has provided clear cut evidence of the value of exercise programs in the reconditioning of these patients. There were two series of these patients distributed in alternate groups. One group was permitted to stay around the hospital with very little attempt at reconditioning, just as has usually been the practice in civilian life. The other group, which may be called the experimental group, was started on gentle exercise after the sedimentation rate had reached ten millimeters in thirty minutes. The exercise was then very rapidly increased in severity from day to day. The non-exercise group remained in the hospital an average of forty-five days and, after going back to duty exhibited a thirty percent relapse. The experimental group which went through the re-conditioning program, spent an average of thirty days in the hospital with a relapse rate of only three percent. In other words, they spent fifteen days less in the hospital, and had twenty-seven percent less incidence of relapses. While the medical officer should be commendably cautious in protecting the interests of the individual patient, there is every likelihood that cautious experimentation on all types of medical cases would show that within a reasonable time after the patient seems to be clinically out of danger, as exhibited perhaps, by the return of the sedimentation rate to normal, buttressed by the observation of the ward officer, the patient can be put into

the reconditioning program as a class 3 patient, with nothing but benefit to him. Due care must be exercised, of course, to see that individual differences in condition, either due to the severity of the illness or to the initial physical condition of the man, are allowed for and taken fully into account in the prescription of exercise for each man.

There is a tendency for the medical officer to be unduly influenced by the small number of cases which tend to be the exception rather than the rule. A few severe disabilities may cause the officer to be overly cautious with individuals who do not exhibit severe disability. Hence, individual differences in disease should be taken into account, as well as individual differences in the condition of the patient, and in the exercise program used on him.

It may be well to summarize in part some of the characteristics of an adequate physical conditioning program for the reconditioning of patients.

Part of the program for a short time each day should be of such intensity - relative to the physical condition of the individual - as to make for definite increases in strength, muscular endurance, and cardio-respiratory endurance. This may require only a total of from twenty-five to sixty minutes a day, according to the status of the individual. Don't let anything interfere with this, or the conditioning will be slowed. This part must be well chosen and well taught.

There should be considerable activity of a submaximal character, lasting anywhere from one to three or four hours a day, for the development of stamina and general physical toughness. Some of this contributes also to mental and emotional stamina and toughness. Individuals are trained to go more nearly to their limits, or to "go all out" as it is sometimes called. That is, he learns to run after he feels like stopping; he learns to continue with calisthenic exercises, after he feels too tired to go on.

There should be specific exercises for individual disabilities. These are especially indicated in the case of orthopedic and other surgical defects.

Part of the program should include sports and games, not only for their conditioning value, but also because they are fun. This type of activity is excellent for the promotion of morale among the men, and is also excellent as a conditioner, especially if it includes a good deal of running.

The work should be conducted on a military basis and good military discipline should be maintained. This should be promoted from the standpoint of leadership, however, more than from the standpoint of general command and driving.

There should be a great deal of emphasis upon the psychological side of the program. It is important to elicit the cooperation of the natural leaders among the men. There will be many patients who can contribute tremendously to the program. Their cooperation should be elicited. These men should be trained in the types of activities that are being done, and they should be used to promote a good spirit and good morale upon the part of the unit.

The work should be adapted as much as possible to the individual. This may be done in a number of ways: It is possible in exercises of the calisthenics type to instruct each man in a unit containing men in various stages of reconditioning - as is frequently the case in smaller station hospitals - to cease any individual exercise when he has become too fatigued in that one exercise. Hence, a man in class 2b might stop with six or eight repetitions, while a man in the same group who would be classified 2A might do twenty repetitions of the same movement. He would begin again with each new movement.

It is possible to increase or decrease the leverages in calisthenic movements, in such a way as to make it harder or easier, for example, an individual doing front bending or side bending with the hands clasped behind the head, has to expend more energy than doing the same movement with his hands placed on his hips. An increase in the cadence will increase the dosage accordingly. It is harder and more energy is required to do an exercise once every half second, than it is to do it once every second. The program is adapted to the individual in what is called the rotating small group gymnasium program, because the activities in this gymnasium program are prescribed to meet the needs of each individual. They do not all do the same thing, but rotate from place to place, each doing what has been prescribed as fitting his needs the best.

In programs such as hiking, or marching long distances, or what is called road work - alternate walking and running - the men may be sent out in different squads, according to their expected abilities. In these squads they do not always keep together in military formation, but may string out a bit, so that the men in poorer conditions go just a little slower than the others. Sometimes the men in poorer condition can be started earlier than the others, and the men in better condition start later but eventually catch up with them.

Types of programs that are good, must be examined to see that they are also the best. For example some work programs are good for the patient, but if not too well chosen may retard his rate of reconditioning, because they are not strenuous enough, and yet they take time away from the more strenuous athletic programs. Each activity must be examined to determine (1) what contribution it makes to the physical reconditioning of the patient and (2) what contribution it makes to the winning of the war.

Some of the main points to be kept in mind are that: The men are to be conditioned as rapidly as is consistent with the welfare of each individual. The work is to be adapted to the individual as much as is possible without requiring too many instructors to give individual attention.

The men are pushed through to such condition as will make them ready to go back to full duty as rapidly as possible. There should be no attempt to put them through a standardized six weeks' course, or anything like that. One man may go through it in three days, and another one in two months. The main purpose of the program must not be lost sight of and that main purpose is to return men for active duty with the Army in the shortest time possible.

CAPTAIN EVANS:

General Collins, Colonel Jones and Colonel Southard: I am back here something as the return of a native. I used to live down in Tennessee, and I want you to know I am very grateful for your hospitality - it is perfectly grand.

What I would like to talk to you all about is the Morale Services Division. You know, morale is a function of command, and we are set up to back you up with materials that will help you carry out that function. In other words, we supply you the tools with which to work. We are a service organization to be called on by you. The materials for orientation and education of Army personnel in general have been and will continue to be available to personnel in hospitals. Any requisitions which you send in for text books carry an automatic priority.

The Morale Services Division is responsible for the provision of materials and services which relate to the maintenance and improvement of morale. The Division is specifically charged with three functions which are of particular importance in the reconditioning program. One - the provision of non-military educational facilities, two - procedures and materials for orientation and information of military personnel, and three - procedures for the selection, training, and assignment of officers for morale duties.

The materials and services - developed for orientation, information and education of Army personnel in general - have been and will continue to be available to personnel in hospitals. ASF Circular No. 73 now makes it possible for these morale services to be utilized to a much greater extent than was heretofore possible.

General Osborn, Director of the Morale Services Division, is intensely interested in reconditioning and will continue to see that every possible aid is made available to the program. Since the original directive on Reconditioning was issued more than a year ago, officers of the Morale Services Division have worked closely with officers of the Surgeon General and Air Surgeon. For many months now the quantity of materials supplied to hospitals has bulked large in our total supply program. We are looking forward to this demand being doubled and tripled.

In addition to the services from Washington, each Service Command Headquarters now has a Morale Services Division; and it is expected that these divisions will work with Service Command Reconditioning Divisions in the same fashion as their Washington counterparts.

Specific materials and services for use in reconditioning are provided by the three operating branches of the Morale Services Division - Education, Orientation, and Information - led by the School for Special and Morale Services.

The Education Branch or Education Program of the Morale Services Division provides six services or materials which may be used in the education part of reconditioning:

1. Correspondence courses in hundreds of high schools, technical schools and college subjects, through the U.S. Armed Forces Institute. Complete information about these courses and other services of U.S. Armed Forces Institute is contained in an envelope of materials which will be distributed. You have already seen the display of materials at the rear of the room.

2. Self-teaching courses. These differ from correspondence courses in that lesson service is not provided. Insofar as possible, the teacher is "in the book" in the form of detailed instructions, step-by-step directions to the student, self-administering tests, problems and questions with answers. To obtain a certificate the Institute provides an end-of-course test, administered by an officer. Though these self-teaching courses were designed for overseas use, they are admirably suited to use in hospitals.

3. Textbooks for class use. These are special Army editions of standard civilian testbooks. Each book is selected for Army use by expert civilian consultants. Many thousands have been distributed to hospitals for use in classes. You have a list of titles in your envelope.

4. Foreign language self-teaching materials deserve special mention. Completely self-teaching spoken language materials have been developed in more than thirty foreign languages on the elementary level. Using phonograph records and a text that spells out the foreign word or phrase as it sounds in English, these language materials teach the student to speak common words and phrases in a few hours practice. Advanced materials that make it possible to obtain a good command of the spoken language are now available in French and Chinese and will soon be available in a dozen languages.

5. G.I. Movies. Most of you are familiar with this weekly movie feature. Containing 16 mm shorts on education, information and orientation topics, GI movies supplement and aid the orientation-education program. Complete information about GI movies and expert advice on the selection and use of films in the education program may be obtained by writing to the Audio-Visual Aids Dept., U.S. Armed Forces Institute. Your envelope of materials contains additional information.

6. School and College Credit Service. This service is especially valuable for men who are to be discharged to civil life. It provides, free, through the U.S. Armed Forces Institute, an official report of military educational achievement for transmission to civilian schools and colleges for evaluation in terms of academic credit. The report may also be sent to employers. The report includes service schools attended, service jobs performed, courses completed with USAFI, and results of GED or general educational

development tests. This school and college credit service has proven to be very popular in test discharge centers. In a test of this service at the Tilton General Hospital conducted by one of our Education Officers, 23% of the men interviewed applied for the accreditation service and took the General Educational Development tests that are a part of the service. The service and the tests were explained individually to each man and an announcement was run in TILTON TALK, the hospital newspaper. The announcement is a good popularized description of the tests. This is how it reads in part:

I G E D tests G I 's Education I

In the past, the amount of education an individual possessed was measured in terms of how far he went in school. Everyone agrees that the greater part of our education is gained outside the four walls of the classroom.

Today, a new yardstick is available to measure your in-service education, or the amount of education you have acquired since leaving school. It is not so much a question of where or how you got your education, but do you have it and how much do you possess?

The United States Armed Forces Institute, Madison, Wisconsin — better known alphabetically as USAFI — has a battery of five tests, on two levels, to measure your educational growth since leaving school. These tests are known as General Education Development Tests.

They will be given to any GI who desires them, without cost. The tests will be administered to you under direction of an Officer.

There are two ways you can use the test results:

1. For Educational Placement — If you plan to continue your education, you may not need to start in school again where you left off. The American Council on Education has worked out, in conjunction with the War and Navy Departments, a policy of Sound Educational Credit for Military Experience, and agreed to use the GED test results as evidence of in-service educational development.

If you have not completed your high school course, and you test up in the upper half of high school graduates, you might be granted your high school diploma on the strength of your score, by presenting your credentials and lists of army schools completed to your local high school principal.

You may save yourself two years of college work in pre-medical, pre-law, pre-engineering, etc., if you show

on the college level tests that you have the equivalent amount of education to "carry on" as is shown by those successfully completing the Freshman and Sophomore years of college.

II. For Vocational Placement - if you left school at an early age, you probably have discovered that this deficiency has been a handicap to you in securing employment or in advancing in your work. The GED tests will furnish you with a new passport or new credentials to show how much education you have, instead of how far you went in school. Excellent results have been obtained by those volunteering for the tests at the two Separation Classification Centers now in operation here at the Tilton General and at Fort Dix Station Hospitals.

No speed test - there is no time limit in taking these tests; you need not hurry.

GED is a POWER TEST - you will not be penalized because of your lack of recent academic experience or formal classroom instruction.

For further information, call Tilton General Hospital (Fort Dix 20), Extension 93, or Fort Dix Station Hospital, Fort Dix 5117.

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The scoring of the tests, the interpretation of the scores, and the making up of the test and accreditation report are done at Institute headquarters.

The test and accreditation service will become even more popular, if Senate Bill #1767 becomes law. This bill, which has passed the Senate, provides veterans with one year of free schooling. The accreditation service will make it possible for many men who take advantage of this year's schooling to obtain advanced standing upon return to school.

Detailed information on all education materials and services may be obtained from the U.S.Armed Forces Institute, Madison, Wisconsin. Special provision for hospitals is made in ASF Circular No.74, 13 March 1944.

Materials and Service of the Orientation and Information Branches of the MSD will be described later by Lt. David H.Humphrey. Lt. Humphrey has just completed a tour of the nine service commands as a member of an orientation team that organized a pilot orientation program in one camp in each service command.

Now, about the training of Education Reconditioning Officers: ASF Circular No.73 provides that educational reconditioning officers be Morale Services trained. It is my understanding that arrangements have been completed for these officers to be trained at the School

for Special & Morale Services in a special four-weeks' course. Colonel Thorndike will undoubtedly give you the details concerning this course, but I believe a general description of the school will also be helpful.

The school for Special and Morale Services is a Class IV installation operating under the control of the Director of Personnel, General Dalton, and the joint supervision of the Director of Training and the Directors of the Special Services and the Morale Services Divisions, Army Service Forces. It is located on the campus of Washington and Lee University in Lexington, Virginia, and is commanded by Colonel William H. Quarterman.

The mission of the School for Special and Morale Services is to provide appropriate training for officer and enlisted personnel assigned to duty in the Army Athletic and Recreation Program, the Army Orientation and Education Program, and the Education Reconditioning Program. Three distinct courses - each of twenty-eight days' duration - are provided. Students are sent to the School by commanding officers from the three major elements of the Army in accordance with quotas allotted to service commands, air service commands, theaters of operation, and the Directors of the Special Services and Morale Services Divisions.

It is the experience of the Headquarters Divisions in Washington and the School itself that a more careful selection of these special staff officers is essential if not indispensable to the achievment of their important missions in the field. WD Circular 287 describes the duties and qualifications of the A&R officer; WD Circular 261 describes the duties and qualifications of the Orientation-Education Officer.

The ideal educational reconditioning officer is conceived as an individual with a consuming interest in presenting the justice of the cause for which we fight, and will be acquainted with the facts concerning the causes, issues and course of the War. He will be capable of organizing and administering a well-rounded orientation and educational program, and capable to advise and guide the convalescent in the solution of his educational problems. He will preferably be a college graduate and will possess the ability to present his views clearly and convincingly. Whenever practicable he will have been a company officer and, as is suggested by WD Circular 73, may be found in considerable numbers among the recovered casualties of the fields of battle.

The instructional program of the School for Special and Morale Services is designed to train selected military personnel so that they may effectively assist commanding officers in developing and maintaining the high levels of mental and physical stamina in troops for combat. It is therefore reasonable to suppose that this program, with minor revisions and necessary adaptations, is appropriate for educational reconditioning personnel as well.

The Athletic-Recreation Course provides administrative and leadership training in athletic sports and games (based on TM 21-221); physical conditioning (based on TC 87); soldier theatricals; soldier music; and the procurement and use of the Special Services funds and facilities. The Orientation-Education Course offers leadership training in methods and procedures designed to create in every fighting man a feeling of individual responsibility for participation in the War, for keeping him well-informed as to the cause of the War and news of the world, and to give him an opportunity to add to his effectiveness through off-duty individual or group study. All of these elements, and others too, are included in the reconditioning Program.

I would like to conclude and say my time is up - it is five minutes over. I would just like to leave one though with you; it has a great deal to do with me, because I think that I may some day be qualified to be considered a "mule skin".

It seems to me there are four points we should bear in mind in this reconditioning program:

1. To find out what the man is interested in - quick.

2. To provide him with something that will help him to follow that interest.

3. To get him to realize that what he does serves a useful purpose - that this program is for him, for him alone, and that he must feel it is his responsibility to cooperate.

Briefly, may I speak of all people - I don't care where they are, who they are, or where they live - they have only three ideas in mind about the man in service:

1. Is he coming back?

2. What is he going to be like when he does come back?

3. What is he going to do when he gets back?

And I think in this Reconditioning Program you gentlemen have a superb answer to two of these questions.

Thank you very much.

LIEUTENANT HUMPHREY:

An effective orientation program can and should be the basic driving force before the entire reconditioning program. In order to see the truth of such a broad statement, the mission of the orientation program must be clearly understood. It is to create and maintain in every officer and enlisted man in the Army a full sense of responsibility for individual participation in the conduct of this war. If the soldier patient truly knows why we fight, his convalescent period will be primarily an obstacle in his path - to be overcome in order for him to return to the line of duty. And it will only be when he has achieved such an inner drive that he will fully cooperate in brushing that obstacle aside.

The orientation program has been directed for all military personnel, but it is in the hospital that it can most nearly achieve full success, as it is also in the hospital that it can be allowed to die a dismal failure because it is here in the hospital that a man's mind tends to turn inward and to question the values, the motives, the reasons behind the events which resulted in his being here.

Because we have found so much misunderstanding in the field about the orientation program, I would like to take a few moments to discuss three things: first, the objectives of the orientation program; secondly, the means of accomplishing those objectives and thirdly, the materials which the Morale Services Division supplies to the Orientation Officers. But I would like to explain that the Education and Reconditioning Officers and the Morale Officers have the same functions in the Orientation Program. I shall speak of this officer as the Orientation Officer here.

For the sake of clarity, the Army Orientation Program is divided into six objectives. The first objective - to know why we fight. Obviously that is the basic motive behind the entire conduct of the war. General Montgomery in Africa made the statement that he thought perhaps the morale was too high among his men because the men did not report for sick call. In other words, they did not want to leave their line of duty. If a man truly understands why he is fighting, the Reconditioning Program will be greatly facilitated because he will want to get back to his duties as soon as possible. It is that which the orientation program is trying to achieve.

The second of our objectives is to know the enemy and by that, we don't mean just his training, his equipment and the size of his forces. We mean that we want the soldier to really understand that the enemy is waging an insidious psychological warfare against us today and has been waging an all-out warfare for a long time. We know that the enemy is dividing us, one Ally from another and internally, within our Nation. We know that the American soldier is told that we are fighting for the British Empire; the British are told that they are fighting for Wall Street, and the Russian soldier is told that they are fighting for capitalism, because they are told that

Stalin has betrayed the revolution. In other words, propaganda is directed where and how it will do the most good. It has no basis or truth whosoever. Gradually we are being divided among ourselves in this Country.

We know that in America the very nature of the people is such as to provide a fertile ground for racial, religious, political and economic differences, and we know that we are being torn asunder by deliberately planned methods. We must make the soldiers aware of that. We must make them realize when they use the terms "damn nigger," "damn Catholic", "damn Jew" or "damn anything else" they are playing Hitler's game and not ours. Hitler and Tojo are paid to do nothing else but that, and if we played their game, why not take our money from the same source? We know, for instance, that the German people here talk about the invincibility of the German Wermacht. When it did not work well here, we were told that Germany was breaking up internally. We are being told that the Nazi party and the War Lords are fighting it out among themselves. It is not being used now, but it has been and will be, as before. We are told all sorts of things about the breakdown in Germany.

We know that again this is a propaganda method to make us feel complacent. We also know that the complacency which results in that type of thinking is perhaps the biggest thing we are fighting against.

We know also that another technique is the technique of a negotiated peace. The Germans say they can't lick us and we can't lick them, so why fight? Unfortunately we read the same material in the newspapers and hear the same things in the radio broadcasts. A negotiated peace is for nothing but to gain time to correct the mistakes that all too closely cost the German Army the war, and if we give them the peace now, it might mean Fascism later. They are not asking for peace now because they are licked, but because they feel that it is the way to accomplish their eventual mission - the domination of the world.

Another objective of the Orientation Program is to know our Allies and not to make it appear that they are perfect. We want our men to understand we are all fighting the same battle against Fascism. It is not great enough to tear us asunder.

Another objective of the Orientation Program is to establish pride in outfit. By that we mean not just a feeling that this is the best outfit, but a real faith in the training and equipment that goes with that outfit. A job satisfaction - a realization that no matter what job a soldier has, even not to his liking - it is a necessary job and must be done; that is how we should contribute to winning the war, and that it is a good thing for him to do it. It gives him a sense of participation, not only in his unit but in the entire war, if he feels that he is working with other men to achieve something purposeful.

The next objective is to know the news of the world and its significance. By that I mean, of course, what is behind the news, not only the mere fact that the news states that so many tons of bombs have been dropped on Germany. If we are going to have the best informed soldiers in the world, and there is no reason why we don't have, we must realize that the current events of today are the historical events of tomorrow; if we wish our men to think in terms of historic events, give it to them in day-by-day happenings. When the time comes after the war and as it goes on, to make decisions based on historical factors, they will have the history as it happened. He himself will have known it.

The last of the six objectives of the Orientation Program is something which shouldn't even have to be stated. It is to have faith in the United States and its future. We know some people in the military service don't have that faith, but we know that the potentialities of America have hardly been tapped and we have a great road ahead of us, and we want our soldiers to know that well enough to fight and die for it. We are not fighting for the possibility of ironing out the imperfections. To accomplish the six objectives of the orientation program we set up a ten-point program in the field. That program has to be adapted to the unit and in case of the hospital, it again would have to have further adaptation.

The first of the ten points is the one-hour per week orientation discussion. That is, of course, the basic orientation program. It is a part of the regular training, and it is to be given during duty hours.

The one hour per week, as provided by the directive, is with the troops. This hour is to be primarily a discussion hour; to belong to the men. Not to get the impression that this is propaganda, we want them to iron out the things and want the feeling to come from them. That one hour per week is well supplied with materials from the Morale Service Division. If these ideas don't come out in discussion, where they can be directed and answered, they will come out elsewhere, or come out in warped ideas. In order to carry out that one hour per week, on the lowest echelon quota, groups of 50 or less, if possible it is necessary for the Orientation Office to brief the material and arrange some sort of a meeting for the Orientation Officer and lower echelon officer--in some instances an hour or less. These men don't have the time to do the research and preparation that is necessary to go into a good orientation hour, so that the officer can bring it to them and also check references. The third point is to establish orientation centers, bringing together all visual material which will help the soldier become better informed--maps, battle lines, pictures, various orientation pamphlets and books and news which is adjusted and analyzed, which makes it easy for them to get. We connect our news, usually with maps, to give them a more concise picture. The fourth point of the ten-point program is the use of the news summaries. Anyone can read a newspaper, however, the

average soldier does not read the newspaper. The Orientation Officer should be qualified to go through the news, adjust it, analyze it, and give it in brief form, by means of mimeographing it, daily or weekly, or over the radio or public address system. This is generally being carried out now throughout the army. The fifth point is the use of the unit newspaper for orientation material, such as editorials, news summaries, cartoons, question boxes, things which will stimulate the interest of the soldier in the events of the world. The sixth point is the liaison relationship between the orientation officer and the men concerned with morale, and others such as the Red Cross, Provost Marshal and Psychiatrist. As they say, sometimes the Military personnel will weep on the shoulder of anyone, particularly the Red Cross Workers. The seventh point is the morale report that the Orientation Officer makes to the Commanding Officer. Of course, that depends upon the Commanding Officer as to how often he wishes them and in what detail. The eighth point is off-duty discussion groups, which is part of the educational program. The ninth point is the use and presentation of dramatic skits, various programs and the use of films. The tenth point is the orientation of officers themselves by the orientation officer for all military personnel. As for the material sent out by the Morale Services Division in addition to the education materials previously mentioned, we have: (1) The films, "Why We Fight" series which you have all seen. (2) Another series "Know Our Allies" — the first of which has been issued about Great Britain. (3) The "GI" Movies. News maps are issued on the basis of one to every two hundred men. They will not go to the men if hung in offices where only two or three men see them. One to two hundred men is not a very large distribution. If they are hidden they do not accomplish their objective.

There are the orientation kits which we have been trying to send out on the basis of one per month. Four kinds are displayed in the back of the room. These orientation kits have books, pamphlets, maps and what we call fact sheets. Fact sheets are written to give to the orientation officer and part-time personnel, information they could not get easily from books or other references. Descriptive maps, books and pamphlets, and anything we are certain will help the Orientation Officer do his job are in the kit. Many more are coming out. Then, we publish a digest for the Orientation Officer. The February and March issues contain particulars and various methods for setting up an Orientation Center such as we have here. We also are publishing a set of eighteen volumes, the first three of which are on the table. Those books will be sent out from time to time in kits. We want to be sure that every Orientation Officer conducts the newspaper, but those services are things such as clip sheets and maps which help him to make his newspaper good. I know you are all familiar with the publication of the "YANK" Magazine which is a very effective force.

Thank you.

[redacted]

Occupational therapy is a form of treatment aimed at the restoration of function in diseased or injured nerves, tendons, muscles and joints, also to functional and emotional mental conditions. In the reconditioning program it has a definite place and it has been established in the Army general hospitals on a treatment basis.

It is of utmost importance that our war wounded should be returned to active service in the shortest possible time. Occupational therapy properly administered will accomplish much in shortening convalescence. It will restore normal function and so assist in achieving this end.

The use of occupational therapy in the treatment of physical disabilities is clearly defined. In this field it should be closely allied with physical therapy which uses heat, light, water, electricity, massage and exercise. Occupational therapy follows through the treatment aims by use of manual activities that furnish normal voluntary exercise for the injured or diseased tissues. It is the task of the occupational therapist to analyze the occupations at her command so that she knows exactly which tissues are utilized in functional motion in performing a certain activity. Occupational therapy in the treatment of physical disabilities activates and coordinates the patient's own interests. His attention is focused on the work being produced rather than on the part which is being exercised. Pain and stiffness are forgotten in his absorption in accomplishment of the task before him. Tendon and joint motion will be freer and more natural and improvement more rapid. Occupational therapy intrisically combines the mental and physical forces in the achievement of adjustment. The variety of activities used may be very broad. The patient may be given occupations which will provide motion similar to those which he performs in doing his regular work. The activity may be graded for strength and endurance. Hence, such things as heavy woodworking, gardening, and wall painting are types of occupations which may be used in the final treatment of a patient.

In the treatment of neuropsychiatric cases occupational therapy embraces a wide range of activity and may be as varied as the imagination and initiative of the therapist or the patient. The program of occupational therapy for these patients must be diversified and progressive and must offer activities that will meet the needs of the intelligent, well educated neurotic individual as well as the dull and unresponsive.

Occupational therapy has too long been considered in terms of arts and crafts. The program actually has a broader concept and includes any and all activities which properly administered may

contain the elements of curative value.

The work will be prescribed by a medical officer, be guided by occupational therapists, and should be graded to meet the needs of the individual patient. For neuropsychiatric patients a daily schedule of activity is desirable.

For the Class 4 patient who is confined to his bed in a cast or in traction or unable to leave the ward the occupational therapy may be diversional or corrective. In any case, it comprises simple activities which serve to induce rest, to control general exercise, to prevent neuroses, and to sustain morale. The closed psychiatric ward should not be overlooked in the program of occupational therapy.

The neuropsychiatric patient may be further encouraged and stimulated to the establishment of industrial habits and work tolerance.

Good posture, and comfortable working positions should be maintained whether the patient is lying, sitting or standing.

Such occupations as the making of camouflage helmet nets, belts, identification tag cords, pistol lanyards, fly tying, or leather bill folds, picture frames, and many other minor crafts or hobbies are used to stimulate interest in activity. Bomber noses and other scrap plastic from aeroplane manufacturers are excellent media for the making of costume jewelry, cigarette boxes, trays, cheese and cake knives. Plastics can be cut with small saws and can be carved like wood. It is clean and pleasant to work with.

The occupational therapist is professionally equipped to determine the type of occupation needed and she begins by conserving work habits early in the hospitalization period. While the patient is still bedridden aptitudes and skills may be detected to develop initiative toward future activity.

For the most effective results the occupational therapy should be prescribed treatment. There should be opportunity for the occupational therapist to receive guidance and consultation from the medical officer as often as possible. For the conservation of time the making of ward rounds with the medical officer at regular intervals is a feasible plan.

Functional occupational therapy for physical disabilities provides intelligently planned activities to assist in the restoration of articular and muscular function. Through such work processes the general condition is improved, physical endurance is increased and mental adjustment is attained.

The class 3 ambulatory patient is sent to the occupational therapy

shop for the purpose of furthering his physical fitness, to strengthen the weakened muscles and increase joint motion in the physical injuries. Special apparatus and adaptations may be devised to suit the particular needs in amputation cases, fractures, or gunshot injuries. Muscle strength and joint motion is tangible and may be measured, and the improvement recorded, so that the therapist and the doctor may know exactly the degrees of increased motion within a given period.

The occupational therapy shop should furnish projects of a heavier type that hold interest for the men. Here the kind of occupation begins to change from that given in the wards and the patient while under treatment still, is directed toward the production of useful articles for the hospital, i.e., file boxes, bulletin boards, medicine trays, thermometer racks, or games and sports equipment to be used in the physical reconditioning program. The woodwork ship should be equipped with a power saw, a lathe and drill press, as well as the bicycle saw and good hand tools which are so essential to the therapeutic treatment of physical injuries. In areas where unusual native stones, clay, and woods are available the carving and modeling of these materials hold interest and fascination for the men with creative talent.

Group projects are good occupational therapy. The soldier fights with and for his buddies. He will also work with and for his buddies.

Printing and the graphic arts offer excellent opportunity for group participation, as well as therapeutic values for the physical injury cases. The hand presses may be used for shoulder and wrist exercise and the foot presses for knee and ankle motions.

The variety of occupations such as news gathering, typing, layout work, type setting, printing, folding, and distributing copy can make the hospital paper a team work project. The printing of Hospital Forms, charts, memos, etc. are worthy projects. Block printing and poster work uses the talents and skill of the more artistic individual and may produce greeting cards, announcements, training aids and posters necessary to instruction of service personnel.

The occupational therapy prescribed should represent more than an order for a man to work so many minutes or hours a day. It must hold interest, and have an urge or a challenge that will motivate participation.

A small photography dark room where the men learn to develop and enlarge their own films and snap shots holds much interest and may be extended into practical channels for the patient and the hospital.

Color gives a lift to everyone's spirit and the talents always found amount large patient population might well be used to decorate the shop, gymnasium or recreation room.

Variety is the spice of life and it would seem unwise to develop the occupational therapy programs in all hospitals after a set pattern. Originality and individuality are the activating forces of all worthwhile endeavor and the occupational therapy department is good proving ground.

Electricity and radio work will captivate the interest of those mechanically inclined. Once a transmitting telegraph has been made interest does not abate for it then becomes possible to practice sending and receiving code. Signal Corps patients can practice and maintain or better their speed in Morse Code by sending and receiving messages. When the project has served its usefulness it may be torn down and be rebuilt by still another interested patient without sacrifice of material. The tearing down and reassembling of a motor or dismounting and reassembling a machine gun may become a study project for the mechanical minds and eventually lead to a project for the repair of small weapons.

These are only a few of the opportunities for exploration through occupational therapy which may well be developed into a program of industrial therapy.

Industrial occupational therapy programs have been proven highly successful when properly coordinated under medical direction by the occupational therapist in consultation with the heads of the departments utilized in the program. Such departments would include the offices, the carpenter shop, the orthopedic shop, the cafeterias, the photographic department and the building and grounds department for flower and vegetable gardening, the library, the laboratory, the motor pool and store rooms. The facilities of these departments would necessarily be made available to patients on an assignment basis, the work to be supervised by department personnel. The selection of activity with relation to the patients physical and mental capacity, his aptitudes and interests are important from a therapeutic viewpoint. Such a plan would involve the assignment of individual patients according to disability and specific abilities, to designated departments of the hospital, the particular occupations selected and arranged by the occupational therapist in concurrence with the medical officer.

Records, a prescription signed by the medical officer for occupational therapy is essential for the protection of the patient and the therapist and should contain sufficient information to serve as a guide to the treatment procedures. The form may be simple but should include besides the diagnosis, the psychological factors, the status of illness or injury, precautions to be observed and the specific results desired in

treatment.

Progress notes may be kept if they will be helpful to the medical officer. Attendance records and monthly reports should be complete but kept as simple as possible.

The essential facilities and requirements for such a program of occupational and industrial therapy are:

1. Space - Adequate rooms for workshops and supplies should be provided. It is suggested that the workrooms be well lighted and above the ground level. Plans and budgetary allowances are arranged for construction of new buildings or remodeling of old ones for occupational therapy shops.

2. Personnel - The number of occupational therapists needed is estimated on a ratio of one to each 250 patients. This ratio is based on the necessity of personnel in Class 3 and 4 programs. The matter of recruitment of qualified therapists has been difficult but is improving and a training program to relieve the shortage of therapists is contemplated in the near future. A qualified occupational therapist is a graduate of a course in occupational therapy accredited by the Council on Medical Education and Hospitals of the American Medical Association or a registered therapist. Arts and craft teachers cannot carry the responsibility of an occupational therapy treatment program.

The value and effectiveness of the occupational therapy program will depend on the training and experience of the therapists who must have a knowledge of the conditions treated and the techniques needed to attain results. However, the therapists needs the interest and cooperation of the medical officer as well as medical direction in order to develop a worthwhile program of occupational therapy. Until recently few qualified therapists were employed in the Army hospitals and occupational therapy in many hospitals has been looked upon as diversion only. Diversional programs give some satisfaction and help the morale of the hospital and the patient but are limited in treatment value.

For the purpose of the program a medical officer should be charged with the direction of the occupational therapy program. If this officer is an orthopedic surgeon, he also directs the physiotherapy program. In this case he would direct the head therapist to designate certain occupational therapy personnel to work with the neuropsychiatric cases under the direction of the medical officer in that section. Likewise, if a psychiatrist directs the occupational therapy program he would have therapists appointed to the orthopedic section to work under the medical officer in orthopedics.

Volunteer workers may be used to assist the professional staff. The Red Cross will furnish a corps of volunteers to assist in the occupational therapy program under the supervision of the

Occupational Therapists. Details of schedule and service will be arranged by the Red Cross hospital field director and the Chief Occupational Therapist.

3. Supplies - are available through the St. Louis Medical Depot according to an approved list. These lists are being revised to meet the growing needs. Budget allotments are provided according to the size of the hospital for the purchase of supplies not furnished on the list. Provisions will be made for increased allowances as the program expands. Your needs and suggestions are welcomed as a study of increased need is now under way.

The handicraft supplies and equipment of the Red Cross now on hand at your hospitals will on request in writing of the Commanding Officer be turned over to the occupational therapy department as a donation after concurrence of the Red Cross Area Officer through proper inventory procedures.

Vocational training will not be carried out by the Medical Department. This is the province of other government agencies. In the last war a great deal of shop equipment and elaborate vocational training provisions were made with but a limited return. It should be emphasized that the primary objectives of the reconditioning program are returning men physically fit to duty.

Much difficulty has been experienced in recruiting and placement of properly qualified occupational therapists in Army hospitals.

The Occupational Therapy Branch wishes to learn your needs. Hospital commanders and occupational therapists of hospitals are invited to write directly to the Reconditioning Division and offer suggestions as to inadequacies of present facilities, stating fully your requirements as they differ from those now authorized. Your suggestions will be appreciated.

Thank you.

MAJOR PRESTON:

General Collins, Members of the Conference:

The Reconditioning Section was started at Nichols General Hospital in May, 1943. Since that time a great deal of experimentation has been done in an effort to organize an efficient program within the broad outlines of the directives. An attempt has been made to utilize the principles which have been developed in civilian rehabilitation work during the past 25 years. The Class I and II program has been operating in substantially its present form for the past five months. Class III and IV has been much more difficult to organize and only recently has been expanded to include all the wards. At the present time there are 327 patients in Class I and II which is 32% of the total number of patients in the hospital. There are 485 patients in Class III and IV which represent 86.1% of the patients in the active wards.
It was thought that it would be desirable, at this time, to describe the program at this hospital in some detail, explaining the theoretical background and reasons for the various procedures to be seen in the demonstration tour tomorrow. We are still experimenting. Our organization is full of flaws which are constantly becoming apparent as we gain more experience, but in spite of this, there is no doubt that the patients derive a very definite benefit from participation in the program.

It has been our objective to so correlate the program that the work which the patient starts in Class IV can be continued as he progresses to Class III, II and I. For example, a patient can start the study of motor mechanics when he is in Class IV. When he is transferred to Class III he can attend the motor repair school; and, after he gets to Class I and II, he can spend a few hours a day overhauling motors in the motor pool. It is conceivable that the patient who has had the benefit of this training will return to duty after months of hospitalization having actually become a more useful soldier during the time he has been away. The program is not well enough developed, at this time, to put all of the patients through this ideal course, but we can handle a number of them in several different branches and it is our objective to give all of the patients the benefit of similarly coordinated reconditioning.

The work with the Class III and IV patients is under the direction of the Educational Reconditioning Officer. A patient officer is assigned to each of the Class III and IV wards. He is in direct control of the Class III and IV activities in his ward and usually has another patient officer assigned as an assistant. One of the noncommissioned officer patients in the ward, who shows particular ability, is assigned as ward leader. The hospital is divided into 6 sections. A patient officer of field grade is in charge of the patient officers working in the individual wards of each section. The hospital is further subdivided into 2 wings with a field grade officer in charge of all of the patient officers in each. These 2

supervisors are, in turn, responsible to the Educational Reconditioning Officer. It is necessary to maintain these various echelons of supervision if the program is to function smoothly with the actual work in the wards being done by a constantly changing of group patient officers. The response of the patient officers to the assignments has been most gratifying. Almost without exception they have been willing and even enthusiastic in their desire to cooperate.

It has been necessary to thoroughly indoctrinate the patient officers and ward leaders. At 8 o'clock each morning they report to the gymnasium where they are given a half hour of instruction in directing the 22 calisthenic exercises which they will give in their wards. On Monday morning from 9 to 10, the Educational Reconditioning Officer meets with them for a discussion of the general and military educational aspects of the work. On Wednesday and Saturday from 10 to 11 the Orientation Officer gives them an hour lecture on the particular points to be stressed in their Orientation work for the next few days. He also gives them mimeographed instructions to be used as a basis for the discussion in their wards. In spite of the constant change in patient officer supervisors, we have been able to maintain a fairly good quality of work in Class III and IV by means of these indoctrination discussions.

In the plans for Class III and IV Reconditioning, one principle has been stressed as being of prime importance; that is, that this is a hospital and the patient is here for medical care, therefore, the program must not interfere, in any way, with the medical work. For this reason, we have tried to limit the ward medical officers' responsibilities to the absolute minimum. When a new patient is admitted, the patient officer gets the permission of the medical officer of the ward to include the patient in the educational and physical training aspects of the program. Ward medical officer selects the calisthenic exercises, from the list of 22 on the card which is attached to the patient's bed, which are suitable for the patient. He signs and dates the card which then constitutes the patient officer's authority to let the patient do these exercises for a week. At the end of this week, the ward medical officer must check and sign another card prescribing the patient's physical reconditioning for the following week. It has been constantly emphasized, to the patient officer, that he must not exceed the instructions given by the ward medical officer for each patient.

As soon as the patient is admitted to the ward, he is interviewed by the patient officer, who fills out a form which covers the patient's civilian experience, education, hobbies, military experience, and his interests. On this personal data form the patient expresses his preference as to the subject he would like to study during the general educational hours. It is the duty of the patient officer to guide the patient's interests into the study of something which will be of value to him during his future military or civil work.

After a patient is enrolled, his reconditioning day starts at 8:45 when he is given 15 minutes of the calisthenics authorized by the medical officer of the ward. From 9 to 10 the patient studies general educational subjects, and from 10 to 11 he is given a short lecture on orientation by the patient officer. The remainder of the hour is devoted to a general discussion on the same orientation subject. The leader of this discussion has been chosen previously from the patients of the ward, a different man being selected each day. From 11 to 12:30 there are no planned activities. The period from 12:30 until 1:30 is devoted to military education, and from 1:30 to 1:45 the patient does calisthenics. This schedule is omitted for 3 hours each week during which the patient officers and ward leaders are being indoctrinated. It was thought best to discontinue the program in the wards during these 3 hours rather than to permit the quality of the work to degenerate during this time when the most experienced personnel were on duty elsewhere.

The Class III and IV patients are under strict military discipline up to the completion of their work day at 1:45. Attendance and attention to duty is obligatory. After 1:45 there are no further required Class III and IV activities and the patient's time is his own. It is considered most important to bring the patient under this strict military discipline, for a portion of his day, at the earliest possible moment, as his mental reconditioning starts as soon as he realizes that he is expected to carry on his assigned studies and physical training in the same way that any soldier is expected to perform assigned duties.

The general and military educational studies are given on a self study basis; a unit of learning being completed in a unit of time. There is practically no class work. This system has been fairly satisfactory as it allows for the marked differences in the ability of the patients to learn, it permits them to study a wide variety of subjects and makes it possible for any of the constantly changing group of patients to start the study of any subject at any time. The medical officer of the ward can carry on his routine work without interfering with the studies of more than one individual at a time. The armed forces institute supplies most of the self study texts used in teaching.

Illiterate patients are required to study reading and writing during the general education period. Each one of these individuals is given a private tutor. These tutors are supplied by the American Red Cross, or from the patients in Class I and II who have had experience as teachers or who have a superior educational background. We have found that about 25 of the illiterates are interested in learning to read and write, while most of the remainder will make some effort to learn because they are soldiers and are ordered to do so. The military education subjects are all required, the students not being given a choice unless they can pass a proficiency test in all of the basis subjects. So far none have been

able to do so. Class III patients who have expressed a desire to learn signal or radio work, or to study motors are sent to the signal and radio work, or to study motors are sent to the signal and radio school or to the motor school for their general education periods. The signal and radio school, the motor school, and the Class I and II school for illiterates are also open on a strictly voluntary basis to any Class III patient who wishes to take advantage of them after his obligatory work day is over at 1:45.

In addition to the group calisthenics, patients who require corrective exercises are given 15 minutes of special exercises six times a day for the treatment of their physical defects. These exercises are given by trained physical education sergeants who are a part of the permanent reconditioning service staff. This is most useful for the large group of patients with knee or back injuries but it is also given for disabilities of other parts of the extreminties.

It has been observed in civilian Rehabilitation work, as well as in the Army, that the most difficult aspect of the reconditioning of a severely disabled man is the bringing about of a proper mental attitude. The dejected patient who has a fixed idea that he can never work again cannot perform satisfactorily any type of physical exercise, no matter how much he is driven. If this attitude can be overcome and the patient convinced that he can recover, there are many types of physical training which will restore him to maximum efficiency. The patient will practically do it himself if he is given the facilities and a little guidance. Because of the prevalence of this unfavorable attitude among severely disabled soldiers, we have felt that the chief objective of the Class III and IV program should be the mental reconditioning of the patient so that then he enters Class I and II attitude will be such that he is able and willing to take advantage of the vigorous physical reconditioning activities which are available.

When the patients are transferred to Class I and II they start on a daily routine which is as nearly identical with that of a duty soldier as possible. They stand all the usual formations. At the present time we have a portion of them housed in barracks. The remainder are quartered in reconditioning Barracks-wards. We were formerly able to house the entire group in barracks, but, due to the arrival of a numbered general hospital on this Post, it was necessary to move most of them back into hospital wards. It was observed that the program operated more satisfactorily when these men were living outside of the hospital.

Their day starts at 6 o'clock in the morning. They stand reveille at 6:15 and after policing their quarters and having breakfast, have one hour of vigorous calisthenics from 8 to 9. For these calisthenics the patients are divided into two groups according to their disabilities, each group being given somewhat different

exercises. From 9 until 11:30 and from 1 to 3 they are on duty working at 35 different jobs around the Post. From 3 until 4:30 they drill, go on road marches, or have mass games and athletics. We are now procuring local maps so that once a week the road marches can be combined with a map reading exercise. The athletic schedule and the road marches vary with each class. When it is thought that the patient will be ready for duty in 2 weeks the drill and athletic period is started at 1 P.M., and the patient works up to a road march of 15 miles at the end of the second week. Many of the patients come from Class III and IV in such good condition that they can start on the 2 week pre-duty schedule when they enter Class I and II. The Class I and II patients are given one hour of orientation a week along with the duty personnel of the hospital detachment. The obligatory study periods are discontinued with the exception of those for the illiterates. These patients are required to attend a class conducted by a teacher from the Red Cross from 4 to 5 four days a week. Attendance at this class is discontinued when the patient enters the 2 week pre-duty vigorous exercise schedule. All Class I and II patients are encouraged to continue their studies after duty hours.

When the patient enters Class I and II it is explained to him that he has been released from the restrictions which are required for the sick patients in the active wards and that he is now to be given the same privileges as the other duty personnel on the Post. In return he is expected to behave as the duty personnel and carry on a full day of vigorous activity. One the day of transfer he reports at the Headquarters of the reconditioning service at 9 o'clock. The "Commanding Officer of the Reconditioning Battalion" explains the objectives of the program. After the patient has been examined by the "Battalion Surgeon", he interviews him and studies the records which were complied in Class III and IV so that he can classify the patient and assign him to suitable work-therapy in accordance with the recommendations of the "Battalion Surgeon". In the selection of the job, the first consideration is the type of exercise required by the patient's disability and the second, the patient's interests and his previous experience.

Among the 35 manual jobs, with all their subdivisions, which are available on the post, it is possible to select work which is exactly suited for the correction of any patient's disability. The work must be carefully supervised by intelligent, well indoctrinated noncommissioned officers. The patient's mental reconditioning is furthered by the requirement that the work produced come up to a standard. Slovenly work is not tolerated by the supervisors.

A few weeks ago I came across an example of the usefullness of this type of therapy as an aid in mental reconditioning. On a Sunday afternoon, when the Orthopedic Brace Shop was closed, I found two patients at work there. They were grinding some braces which they had started the day before. They explained that they were working because they were more interested in this than in

the available recreational activities.

This type of physical conditioning was selected for inclusion in the physical reconditioning program here because, during the past 20 years, it has been demonstrated by civilian rehabilitation institutions that this is an unusually good technique for use on patients who have lost the desire to get well, or who do not feel that it will be possible for the strength and dexterity to their injured extremities to be restored. It has been shown that if these men can be given familiar work, they will eventually become so interested in trying to produce results that they will unconsciously exercise their disabled extremities to the maximum. In as much as the most difficult aspect of the reconditioning process, in this hospital, is the development of the enthusiastic cooperation of the patient, this work-therapy technique which has been proven to be unusually good for this purpose is properly included in the program. The results have been satisfactory during the 5 months that it has been in use here.

Once a week all Class I and II patients are re-evaluated by the Chief of the Section from which the patient was referred to the "Reconditioning Battalion". This examination is done in the presence of the Battalion Surgeon, the Physical Reconditioning Officer, and the noncommissioned officer in charge of the work-therapy details. The Medical Officer advises the nonmedical personnel regarding the physical training program for the patient during the next week and they, in turn, advise the medical officer about the patients performance of the various exercises during the preceding week. Together they lay out the program for the next week. We are convinced that the program cannot be operated satisfactorily without this close liaison between the medical and physical training officers involved.

We have tried to set up the program for Class I and II in such a way that it includes a proper mixture of work-therapy, drill, hikes, athletics, and calisthenics each day. By this means the exercise program can be varied, so that it maintains the patient's interest and keeps him up to maximum effort throughout the entire day.

The officers go through about the same course of exercise as the Class I and II enlisted men except that they do not do work-therapy. An Occasional patient who has a lesion for which work-therapy is especially indicated is permitted to work in one of the shops. While the officers are in Class III they are assigned as instructors in the training program for the Class III and IV enlisted men. As soon as they are ready for Class II they are transferred to the Officer's reconditioning wards, where they are examined by the Medical Officer of the Reconditioning Program and placed on one of the three exercise shcedules. As their condition improves they progress from one group to another until they are able to make a 15 mile hike.

When an officer is in Class I and II he is busy from 8 in the morning

to 5 in the evening, the morning being taken up with the training program for the Classes III and IV enlisted men and the afternoon being used for physical exercises. All of the various exercise courses for officers are conducted by physical education sergeants under the general direction of physical reconditioning officer. The Class II exercises are arranged so that they progress through a 4 week schedule but the majority of the officers do not remain in Class II for the entire course. After a week or so they usually can be shifted to a more difficult program. Occasionally an officer is found to be unable to carry on in reconditioning and is sent back to the wards for medical or surgical treatment, or to be presented to a retirement board. In such cases, the reconditioning program furnishes an excellent means of determining the patient's actual physical capacity. Some of the officers who have military or civilian occupations which can be utilized, are assigned work at their professions during the morning rather than to the training of Class III and IV enlisted men. Medical and dental officers, engineers, and men who have had experiences as company commanders are frequently given these assignments.

The CDD cases are not a problem in this hospital at the present time. We have very few of them. These patients are included in the reconditioning program along with the other men. As soon as they are officially informed that they are going to be given a CDD they are immediately transferred back to an active ward where they remain for the few days which elapse before they are discharged from the Army.

The neuropsychiatric patient is a more difficult problem. They are given the same Class III and IV training as the other patients with the exception, that they do not attend the signal radio school or the motor school. When they are ready for Class I and II they are not transferred to the reconditioning wards but are given a very easy course of physical reconditioning which includes calisthenics, mass games and hikes. They are handled as a separate group under the supervision of a physical education sergeant who has been well indoctrinated by the psychiatrist. The psychiatrist keeps in close touch with the program as it is applied to his patients. It has been his suggestion that these patients be given exercises which they can complete successfully rather than being subjected to a physical training program based on the over-load principle such as is used for all the other patients.

Since the reconditioning service was organized we have been trying to keep the administrative details to a minimum, but as the program has become more complicated it has been discovered that chaos results unless proper administrative control is maintained. A number of daily rosters must be kept so that the physical education sergeants and the other personnel can make an accurate check on the patients assigned to the various details. At the present time we have a rather complex administrative set-up, but, it is our hope that, with more experience, we will be able to get the same results with a considerable reduction in clerical work. The

reconditioning service is organized at the present time with the Chief responsible for the entire program. The Educational Reconditioning Officer is in charge of Class III and IV; and the Physical Reconditioning Officer is in charge of Class I and II. The Physical Reconditioning Officer is also assigned as Executive Officer of the entire service. A battalion headquarters is maintained with a sergeant major in charge of the administrative office. The Class I and II enlisted men are divided into 3 companies with a patient officer acting as company commander for each. Most of the personnel involved in the administration of the reconditioning program are patients. The constant changing of responsible administrative officers and men makes the operation of the program difficult, but it was thought that the assignment of these men, for half of each day, to the administrative duties they would ordinarily carry on in their own organizations, was a valuable therapeutic measure.

In closing, I would like to call your attention to the charts which are displayed at the rear of this auditorium. These list the activities of each day and may serve to clarify my remarks. Since they were drawn, minor changes have been made in the routine shown. For the tour which will be held in the morning we have selected a few of the more important activities of the week, hoping to give you some idea of the operation of the program which I have just outlined.

COLONEL MONDIK:

While they are waiting to put up the lantern, I would like to say a few words about the last two talks. I think we have all heard the most commendable of programs about reconditioning. This hospital has certainly come a long way in trying to solve the problem without personnel. You have heard how patient officers, up to a number of 50, can be used and collaborate in the program until we are able to get, locate and train the qualified personnel we are anxious for you to have. However, Colonel Southard, I congratulate you on how well you have been able to put it together.

I am going to talk this time on organization and how it has been set up. It has been difficult to picture a new division entering the hospital and medical department organization, but we have what we believe is a basis which may be changed from time to time on which one can visualize the organizational charts, the actual set-up.

(Organizational charts were shown giving the relative echelon and position of the officers and training officers on the program.)

Now, after our last meeting I showed these slides and there is one activity we did not show on that, and that is the diversional and recreational activities. Part of that might well be under the Special Services Officer, athletics and recreational; and part under the Red Cross, bedside recreation in the arts and skills. I hope by the next time that the conference is held we will have that slide but it is complex. I will try to sketch our present set-up on the blackboard for those who will be interested. Instead of three branches under the reconditioning officer there are four, diversional and recreational activities are the fourth, and the command channel to the Commanding Officer is not through the reconditioning officer direct.

(There was shown on the blackboard a diagram carrying out every detail of the Hospital Organization.)

COLONEL HILLDRUP:

I would like to remind the listeners to get their questions ready for the final discussion. We are quitting promptly at 4:50 in order to attend a formal retreat.

Next party to be heard from will be a comment on the meeting so far held, by Brig. General C. C. Hillman.

General Hillman desires to reserve his remarks for a later period, so we shall now have some observations by our host, the Commanding Officer of this hospital, Colonel Southard.

COLONEL SOUTHARD:

General Collins, Friend Colonel Hilldrup, Conferees and guests in the balcony: The overall plan of the Army's Reconditioning Program has already been very comprehensively covered by previous speakers, both here and at the recent Conference at Shick General Hospital at Clinton, Iowa. While not present at the Shick Hospital Conference I had the privilege of studying its minutes which have been of inestimable value to me. You have heard and read much of the technical side of reconditioning and I should like to devote my few minutes to giving you the first hand impressions and experiences of a hospital commander who has struggled through the vicissitudes of trying to establish a reasonably satisfactory Reconditioning Program the results of which good, bad or indifferent, you may judge for yourselves on your rounds tomorrow.

In setting up a program a Commanding Officer must have some latitude and I have taken it wherever it did not conflict with any existing policy. My remarks will be confined mostly to what I think would be of some interest to Hospital Commanders. Having been through the development of a program perhaps I can point out some of the pitfalls that I stumbled into which they can avoid.

Before going further I wish to tell you that my first reaction to the initial directives last spring was a feeling of anguish. To me, who was busy just receiving and shaking down my first convoys of patients, it was an imponderable thing superimposed upon an already overloaded structure.

Since we had no clear concept of the program we lagged at the start not knowing which foot to put forward first. We made two fruitless surveys of the surrounding country in search of suitable facilities to house the program away from the hospital. Then we sinned again by lapsing into a state of innocuous desuetude for a time. Then we started. It was a primitive start. A vacant ward was set aside as the pilot model and a medical officer selected to operate it as a reconditioning ward. The choice of Medical Officers for the job happened to be a fortuitous one. He was an enthusiastic type of officer with a history of having been a high school pedagogue, an amateur athlete (who didn't mind going professional at times) a coach for various athletic teams and a flair for histrionics. Athletic equipment was purchased, games organized and the program off to a start. An additional ward was soon required and then a third when the reconditioning officer was ordered away to school.

The program rocked along more or less on its own momentum for a few weeks until a field grade Medical Officer came along who had previous experience in reconditioning his patients in civilian life. Upon being exposed to our embryonic program his fingers

fairly itched to get hold of it. He was promptly detailed Reconditioning Officer in addition to his other duties whereupon he began at once to overhaul the existing program with the view of revamping it into a well integrated comprehensive and workable plan.

So much for the birth and development of our local program and now for some observations based on personal experiences.

Medical Officers were used to get the program under way. Under the present set-up the Reconditioning Officer and his assistant are both medical officers doing this work in addition to their other duties. While not strictly in accord with policies originally enunicated, I am of the firm conviction that medical officers insofar as practicable should be used at the top of the organization. By nature, background, a highly developed sense of human understanding, and by the prestige of their profession they are superbly qualified to lead the sick from their beds to their feet and finally to the gate through which they pass to duty. In my opinion the need for close supervision by medical officers cannot be over-emphasized. I say this with full knowledge of the deplorable shortage of medical officers. Let us have a few of them even if only on a part time basis.

Another observation, not original, which has been stressed many times before. Start out with enthusiastic personnel or the program will not prosper. A few enthusiasts at the head of things will sell the job to all without conscious effort. Remember enthusiasm is a contagious thing and not easily stopped when it gets going.

But where does one get enthusiastic personnel ? Obviously it must come from the personnel you already have at your disposal - and you have to seek it out. There is no use looking for it however until you have sold yourself. Some Commanding Officers will find officers who are "naturals" and will get off to a good start. Others will be less fortunate and have a tough row to hoe for awhile. As soon as the program begins to take on a concrete form it will take much less pushing from the top.

The Reconditioning Program is a revolutionary step to some of us older files and with pressure put on us from above and favorable publicity stimulating us from below we certainly will not lack in outside stimulation to spur us on.

Now for Dicipline. This subject has been discussed throughout the ages and the basic principles remain the same. It is only the manner of application of these principles that vary among Commanding Officers. There is no short cut or favorite formula for building dicipline and each commander has to work it out for himself depending upon such leadership as he may possess.

I find dicipline is more difficult to maintain among patients than duty personnel. The chief reason appears to be that many patients are not with us long enough to become indoctrinated with what is expected of them in their new environment. After they have been with us awhile they begin to fit into things. Of course, there are other contributing factors among which is the belief of some patients that sickness gives them license. Then, there is the well known scourge of all hospital commanders - patients from overseas demanding furloughs almost before they have been assigned a bed, declaring they had been promised a month's furlough as soon as they arrive. I frankly think they have a just complaint when the furlough is not immediately forthcoming. Sympathetic explanation by the Ward Officer of the reason why a furlough cannot be given at once tends to relieve the pressure but is morale shattering at best.

The introduction of the Reconditioning Program obviously is a godsend in maintaining discipline as the patient does not have so much time to loll around the ward and become introspective. However, discipline problems do arise and have to be met daily. The same principles in maintaining discipline are applied here to patients and duty personnel alike. I have never been able to see a good reason why an ambulant patient should have more license in his conduct than a duty soldier. All derelictions require an accounting for. To "pass" up one offense certainly is inviting a second one. "To get away" with an offense is an act of "heroism" in the eyes of some of the offender's associates who in turn are apt to try some "heroics" themselves.

Admonition and reprimand are resorted to when judgment dictates that that is quite sufficient to meet the ends of dicipline for the case in hand.

Withholding pass privileges takes care of minor offenses, the great majority of which is the overstaying of passes by a few hours. First offenders going absent without leave for a few days usually reach the Summary Court. "Repeaters" and those absenting themselves for periods of a week to ten days and longer can reasonably expect trial by a Special Court Martial. When the interests of discipline require, patients are sentenced to confinement at hard labor the same as duty personnel. Obviously, while hospitalized the hard labor is not actually imposed and the confinement carried out in the Enforced Treatment Ward. We have been experimenting lately with the plan of "paroling" cases in the Enforced Treatment Ward during reconditioning program hours in order that they do not fall behind in the program, lose interest, and soften up. The results so far have been most encouraging.

A word on administration. We expect some criticism on the amount of paper work we do especially in view of the announced policy that paper work should be kept to a minimum. Perhaps we can

eliminate some of it later on but it has been our experience during the developmental stage of the program that fairly extensive records have to be kept if individual task-assignments are made and individual progress is closely followed. This is too much to be carried in the head and should not be guessed at. Without records there is no way of checking absentees and you will lose patients out of your program without knowing it. When that happens the question of discipline again raises its ugly head because you have required a duty to be performed and have not taken the pains to enforce it.

The Headquarters or more properly the Administrative Offices of the Reconditioning Section is housed in a separate barracks with some temporary alterations made to adapt the building to the purpose. With the recent expansion of the program adequate office space, library space for technical books, and a small class room - all under one roof had to be provided.

I am convinced now that the magnitude of the program required of us requires a centralized reconditioning headquarters with ample facilities. I think we toyed too long in trying to operate a "headquarters" in small ward offices scattered here and there. I expect some of you will feel that our Reconditioning Headquarters is too formidable a set-up. Maybe it is, but before judgment is passed on us too quickly - give us a chance to crystallize our plans out a little more. We do not know all the answers yet by any means. Perhaps when we get our feet on the ground, many simplifications of procedure will suggest themselves.

Major Preston, Reconditioning Officer of this hospital, has told you something of the details of our program and how we use patient officers to compensate for our shortage in training officers. From the new T/O outlined in Circular 73, it looks as if rosier days were ahead for us as far as training personnel is concerned. When this additional personnel arrives a considerable burden will be taken off the shoulders of the two medical officers who are by necessity devoting too much of their time away from their principal duties.

It is an old axiom that all is not gold that glitters. Upon the acquisition of additional duty status training personnel, there will be the greatest temptation to require less assistance from the patient officers in conducting the program; and, if we succumb to this temptation, we will have lost our ability to inspire some half-hundred patient officers to work long hours daily with cheerfulness and enthusiasm. And right now I want to go on record in commending the patient officers here for their voluntary and enthusiastic response to the call for their help in maintaining the program. (You will see many of them on their jobs tomorrow morning.) And do not let us overlook for a moment the fine contribution that selected enlisted patients are making in helping us along.
We have some of them helping us now whom we would give our

eye teeth to keep permanently - but naturally they have important jobs back at their organizations to which they will soon return while others come along to fill their places.

Before closing my observations, I want to emphasize again that we have nothing perfect or near perfect to show you here. We are far too new in the development of our program to have anything of finality to offer. Innumerable "rough spots" are constantly cropping out - and will continue to crop out for some time. If everything was clarified, there would be no occasion for this conference. We will appreciate all the help you can give us.

COLONEL HILLDRUP:

Out in the Sixth Service Command, we are going to establish a reconditioning campaign or activity at Camp Grant, Illinois. Camp Grant is commanded by Brig. General James E. Baylis whom we have known for years. At this time, I am going to call on General Baylis for a few remarks on the reconditioning program.

BRIG. GENERAL BAYLIS:

General Collins, Colonel Hilldrup, Conferees, what I shall have to say will be rather rambling in nature because I came here with no well-formed idea of this program. I have had one thought though since being here, and that is, that we should not lose sight of the mission that we have in mind when we undertake this program. That is, in effect, to return as many men to useful service in the army as soon as possible.

Now, as is usual in various specialists, when they present their side of a problem they perhaps become a little too enthusiastic, or impress us that way, in the importance of their particular scope of work in this connection. As we listened to Dr. McCloy, in his fine talk on the importance of the physical development, as we listened to others on the importance of the educational program, as we listened to others on the importance of the orientation, and finally the importance of occupational therapy - in connection with this work, we might well, those of us who are listening, might well reach the conclusion that the program is an end within itself. And we might get involved to just that extent if these various phases of the work are not properly analyzed and the importance fitted into the program.

I think perhaps one phase of it has not been sufficiently emphasized, however. It was brought up very well in Major Preston's speech as to the application of the program here in this hospital. We must not forget the importance of discipline, the importance of doing those things that make a man a soldier - a better soldier. There are many who might be surprised, those of you who don't happen to be directly connected with this work might be surprised to learn there are a great many soldiers returning from overseas who really did not have the fundamental basic training. They can stand a great deal more training as a soldier and I, for one, want to emphasize the importance of making a man realize the necessity of becoming a well-rounded soldier, a well qualified soldier to perform some particular job in the service, as a morale factor with equal importance with some of those things we have been emphasizing. I don't believe there is anything as stimulating and as morale building to an individual, whether he just came from civilian life or whether he is a patient in a hospital, to have him become a well-disciplined and a well-rounded soldier. When you do that, many of these things will be of minor significance. I simply want to emphasize that particular phase so we do not get lost in the forest when we undertake this work.

BRIG. GENERAL PRESTON:

General Collins, Colonel Hilldrup, Colonel Jones, Fellow Officers: I came here today, like General Baylis, to go to school and I have gained a great deal from it. I went through the same things that Colonel Southard mentioned when we started our program, and I think the conferences we are having are going to do away with many of the pitfalls officers who started the program earlier had to step into, as it were.

This mighty fine program, as gone over by Major Preston, I am afraid at my hospital is not being duplicated, as we haven't enough men to do it. If we are going to do that, I may have to call on my friend, Colonel Hilldrup, for some more personnel. There are a few things I want to say from my observations: In the first place, you can't get away from the fact that as long as you have these people under your control as patients, and by that I mean a medical officer must direct the Reconditioning Program, no matter what the scarifice is. He must talk "turkey" with the Chief of Service. Ward officers are down the line.

At my hospital, the Chief of Service must pass on the condition of these men. Of course, the ward officers must pass on it too. But the responsibility lies in the Chief and Assistant Chief. In order to do that you must have a medical officer somewhere to know what they are talking about, and who talks the same language.

You must have a separate organization - you can't run this organization on a shoe string. You have to have a headquarters. How it is going to be, I don't know; but as General Baylis says, we are going to try to carry all these things out. Another thing is, in my estimation, that this thing is so large now it is really a separate service. You have not only the Medical Service, Surgical Service and Dental Service but you must also have a Reconditioning Service and the quicker we make up our minds to consider it the better off we are all going to be. I agree with everything that has been said but there is one thing we must do with the patients in the I and II Classes. Get them away from the hospital at some little distance. On the other hand, if you are going to send them away to another place you discharge them from your hospital. Therefore, they are not your patients. As long as they are your patients, you have to have them somewhere near, preferably within a few miles of your ground. We can't all have the same set-up. My hospital goes fourteen stories in the air, and this is fourteen stories on the flat. We can't do the same thing at either one of them.

We are going to try to build up the program to fit Percy Jones General Hospital and do the best we can to get these people back to duty in the best possible condition, both mentally and physically. But, in order to do it, as I said before, we are going to set up a separate service and we must have trained men to do it.

COLONEL HILLDRUP:

This completes the afternoon session and the conference will adjourn to meet again at 8:00 P.M. for the Panel Discussion.

Colonel Jones:

The meeting will come to order. We will proceed with the program as outlined. I am going to call the victims to come up on the stage:

General Hillman
Colonel Childs
Colonel Blakely
Colonel Thorndike
Major Preston
Dr. McCloy
Mrs. Kahmann
Colonel Martin

Colonel Martin will conduct this panel and he has a deck of cards which he will shuffle.

Colonel Martin: This is an ancient form of torture that man has been subjected to for many, many years. In fact, you could go back to the Bible when Maaman came to the Prophet Elijah who cured him of his leprosy by dipping him seven times in the River Jordan, whereupon the King of Israel wanted to know how he did it.

Q. In view of the desirability of separating Class I and II from the hospital, what is the plan as to the extension of facilities in the Hospital when sufficient housing facilities apart from the hospital proper do not exist?

A. (Colonel Thorndike) ASF Circular No. 93 was issued prior to my departure from Washington which requested a study be made of possible sites for convalescent centers as part of the plan for further expansion of convalescent care for groups I and II. This is only a study; we have not come to a conclusion, but many of these centers will be established. There is also the possibility of doubling up barrack space, double decking detachment barracks so as to make open barracks I and II in the hospital area. However, that is not as desirable as getting groups I and II away from the hospital if you can find a site.

Q. Will each hospital have its own reconditioning program or will there be several large centers?

A. (General Hillman). I think there will be no uniformity in the matter. Some of us are inclined to believe that so far as possible it is desirable to run all I and II, that is, our patients in the advanced reconditioning section, near enough to the parent institution so that consultation service may be rendered to the patients in the advanced reconditioning section from the parent institution. We feel from the viewpoint of professional service that these cases in the advanced reconditioning center who may be problem cases, especially those who may be dis-

inclined to welcome return to duty and may have plenty of tricks they will pull on the doctor will be at a disadvantage if they have to face the same doctor. In other words, he is acquainted with them and we feel by his handling the case all the way through he can determine the type of duty to which he is to return and it will be more efficiently handled. We realize there will be a number of hospitals that have no barracks or rentable or otherwise obtainable facilities in the neighborhood that can be set up for Classes I and II, and in such instances it will be necessary to have central large convalescent centers to handle I and II Classes from several hospitals and possibly have its own professional set-up.

Q. What is the best way to handle hospital charts of I and II patients with regards to progress notes, etc.? Should the original ward officer or reconditioning officer make the final evaluation diagnosis and summary?

A. (Major Preston) Here at this hospital we have not had enough medical personnel on the Reconditioning Service to do more than just the minimum amount of paper work on the charts. We have not accepted any patient in the Reconditioning Classes I and II unless his chart is finished, including the 55A sheet and summary. Every once in awhile we have to change this front sheet and summary after the reconditioning exercises have shown that the clinical situation has changed, but it has worked fairly well, I mean, having the chart completely finished when it comes to reconditioning, and we add another final summary which can necessarily be short on to the original one. The final evaluation of the patient is always done by the Chief of Section of the department from which he has come in cooperation with our own medical officer.

Q. What will be the effect on the reconditioning program of that part of Circular 100 which requires the discharge of the wounded soldier returnable to special assignment only on his own request?

A. (Colonel Childs) I assume this question refers to the following quoted sentence in Circular No. 100:

> "Enlisted men who are physically unable to render useful military service in any assignment that can reasonably be made available will be discharged immediately under the provisions of AR 615-360. If overseas, they will be returned to the U. S. for discharge. Exception to this policy is authorized in the case of combat-wounded enlisted men who, as a result of their wounds, are qualified for limited duty only. Such individuals may be discharged at their request."

Exception to this policy is authorized in the case of combat wounded enlisted men, who, as the result of their wounds received in combat, are qualified for limited duty only. Such individuals may be discharged at their own request. There is a later question on this subject which I will answer when it comes up. However, as I understand it one of the objectives of the reconditioning program is to return soldiers who must be returned to civil life in the best possible physical condition. If that is a true statement then I would presume that the program would have achieved its objective, that is if you have to return them to civil life you return them in the best possible condition, and that is one of the objectives of the program.

Q. What relation has the CDD to the reconditioning program?

A. (Colonel Childs) I think it has exactly the same relation. If you know a man is going to be discharged, nevertheless you will place him in the best possible physical condition.

Q. Colonel Jones wants to know if you would discharge this man as a wounded soldier under Section II?

A. (Colonel Childs) Yes, it would appear obvious, but I would prefer to refer to the author of Circular 100 and will answer that later.

Q. Is the author of Circular 100 present?

A. No, he is not.

Colonel Hilldrup: We put that question up to the Staff Judge Advocate of the Service Command and he said that the word "may" might be interpreted as optional.

Colonel Childs: Yes, but does that answer the man who wrote it? Colonel Lynch wrote that and was present at the Schick conference.

Colonel Clyde Beck: We have already asked the Surgeon General the answer to that question and the conclusion I got is that it is optional with the Commanding Officer whether or not the enlisted man is discharged from the service.

General Baylis: May I inject a comment there? I think that is a very vicious policy, and the point is why leave it optional? Why not treat everybody alike? When you put a policy up as optional that has so much involved, it is a vicious policy. Speaking from my own personal opinion and not from the book, I do not see how the Commanding Officer could do that and not get in a difficult situation.

Colonel Childs: I do not think I am in a position to say the final word. However, in the correspondence that came to the

Surgeon General's office I recall some discussion of it before I left the office a few days ago, and we thought the same principle applies to an officer who comes from general service to limited service. He comes before a Retiring Board, whatever the condition was which necessitates his being reclassified from general to limited service. If that were in line of duty, he would be retired as line of duty. He would go through the same procedure comparable to the CDD of enlisted men. We may have been a little out of turn in rendering an opinion on it. It seems to me if you are going to discharge a man because of reclassification to a limited service status, I do not see how you can do otherwise but discharge him on a certificate of disability. That is one side of the question.

Colonel Beck: May I inject a word? I was talking to Colonel Chappell, Woodrow Wilson General Hospital, Staunton, Virginia, and he told me he had written to the War Department to ask whether the man would be discharged under Section II or X. They came back with a very positive statement he would be discharged under Section II. The real question is whether he would be discharged at all.

Q. Is the school for the training of physical training reconditioning officers now open and can a request for attendance be submitted for this training?

A. (Colonel Thorndike) The school is about to open. If you have a candidate or possible candidate to enter that school, put his name forward so we can hasten the opening of the school. The school is to be a 28-day course. The curriculum has been approved by our office, and I hope in a week we will have something positive to announce concerning the formal opening of that school.

Q. What is the nature of this instruction, is it going to be physical conditioning, educational, orientational, occupational therapy, all in 28 days?

A. (General Hillman) I can only say that so far as we have worked out the program it is largely physical reconditioning. There is a school in orientation and information already established to run 28 days. It will not parallel that school, it will be primarily for physical reconditioning. Those of us who are going to conduct these programs have got to look forward to educating about three officers; one for physical, one for educational (which includes orientation), and the other for occupational therapy. Occupational therapy is for civilians only to date, and they are all qualified personnel brought from civilian life.

Q. Are they available and ready for assignment?

A. (Mrs. Kahman) They are becoming more and more available.

There are quite a number of new graduates who will be getting out of school between now and June, also consideration is being given to emergency training courses for occupational therapists, which should turn them out in large enough numbers to take care of the need. This course has not been established as yet, but it is very much in the thinking, and will probably be an actuality in a very short time.

Q. Should soldiers returned to duty under 293 be discharged at any point of reconditioning by the medical officer when we consider the type of duty each one is expected to perform?

A. (General Hillman) It is my opinion you cannot hope to discharge every man from your advanced reconditioning section qualified for general service. You are certain to have a good many individuals who will be discharged from the hospital as limited service personnel. If the man has a definite assignment to which he is going to return, and we will say it is a sedentary assignment, I see no reason for trying to handle that man up to the point where he can carry a pack and march 15 miles. He was not able to do that before he came in the hospital. If he is going back to the same assignment it would seem to me a waste of time to try to build that man up so he can do that before discharge from the hospital.

Q. Will that man go back to the same assignment or go back to a pool?

Colonel Conner: I think that is true, but so far as the reconditioning divisions of station hospitals are concerned, in most instances, you will know on what assignment the individual is going at the time of his discharge from the station hospital; that does not apply to general hospitals, and it seems to me if the man is being discharged to a replacement pool or to a reassignment center for general service from a general hospital, you should try to have him fit for general service as a foot soldier.

Q. (General Baylis) I am seeking information about something we all have to think about in this. We have this group of I and II that we say should be developed to the maximum point physically so they can return to service. The puzzling question about that to my mind, as a medical officer, is just where is this point, where is this point for infantrymen, for cavalrymen, for signal corpsmen, for quartermaster, and where is it for medical corpsmen? If you turn them over to us as medical men we can go right thru the whole program. If he is an infantryman how far do we carry him before we turn him over to the infantry? We agree he should not be given 8 hours a day physical reconditioning on any reconditioning program, or if we did give him that, would it not be better if we devote some of that time to giving him physical

training along with the particular line which will make him a better infantryman, if he is an infantryman, and which would qualify him ultimately to return to the infantry? I think that is something that should be developed, so we understand just where we are. In other words, how far is the Medical Department to go with this program, how soon and at what point do they come to the line for completion of this training? If we keep them under the Medical Department we can train them physically, yes, but isn't there a lot of time being lost that might well be devoted to the use of their particular weapon, supplying training which might well be put in the period to make them better soldiers and save time? In the long run Class I and II return to full duty. If he is going back to the Infantry or Cavalry, at what point do we turn him loose?

General Bastian: Some simple test must be applied for men so they can go forward and these are the things I would like to mention. Talk about a man marching 15 miles. Now we can take a man with a neuro-injury. He can march 15 miles but he cant do anything else, so I think there should be some simple basic test so that a man can go to any outfit. I do not think we can train them so that he can go to an Infantry outfit, a tank outfit or any outfit. We can train them so that they are ready to go back to any outfit.

Colonel Martin: I am going to ask two officers to answer that question.

Colonel Blakely: That was rather a long question. It is my opinion, and my own opinion, that the Medical Corps in determining these battle casualties and reconditioning battle casualties, will go into the situation to the extent of whether this man can be an Infantryman again or not. He may be fitted for general service with some other job he can do, yet he cannot be an Infantryman. War Department Memo W-600-44 published 26 January says that "battle casualties other than Army Air Forces discharged from the hospitals who are incapable of performing useful service in the arm or service accordingly assigned, will be reported to the reassignment centers that have been established."

Q. (Colonel Martin) How far in your opinion should the Medical Department go in training these men before turning them over to the different arms of service for special training, that they give them in that particular arm?

A. (General Hillman) That is a very hard question to answer from the medical standpoint. I think you could go so far as to determine whether or not this man could go back and take his original job. If you feel that he is unable to do that, then you could start the training of this man for some other service for which he will

be fitted. There are many places that a man can fill and yet he cannot go back and be an Infantryman again. I cannot tell you from an Infantry viewpoint how far that man can go. It depends upon his injury and physical condition.

General Baylis: It looks like the first objective would be to determine whether or not he is limited service.

Colonel Blakely: Personally, I believe that would be the first thing you would determine. Is a man capable of doing limited service or is he capable of doing general? Then it seems to me the Medical Department should discontinue every effort right there and then he could go to any line assignment.

Dr. McCloy: This matter of telling him just how far to go is not too difficult because we have now batteries of tests that are well worked out. In May or June 1943 we tested some 7500 of the Ground Forces and then in the fall, August and September, we tested 5000 of the Air Forces. Those were tested and standards worked out. These standards are available and they will go in this manual of reconditioning, so that in determining when a man who has no specific disability such as an operative case who has a shoulder that does not go back or a knee that does not go back or an ankle injury from a gunshot wound, the question of physical condition is so we can answer that readily with tests. This other point of determining whether the patient is ready to go back to duty is left to the judgment of the surgeon. There is a fundamental principle involved here in determining when this man should be discharged.

Our principal job, as representatives of the Medical Department, is to see that this man is completely recovered from his physical condition that brought him into the hospital that he should be considered completely recovered when his pathological condition, whatever it may have been, is in fact recovered as we would consider it so from a medical viewpoint, and that man has shown ability to engage in full activities of basic training. In other words, it seems to me that individual should not be held in the hospital under a Medical Department supervision for any special training in his branch of the service. It seems to me entirely impractical to teach men in Infantry, Cavalry, Signal Corps and all other branches, but generally all personnel has to undergo basic training; and it seems to me we should stress basic training and when a man shows his ability to partake basic training he should then be turned over to his organization if he is in a hospital or to a distribution center or such other place as regulations prescribe for disposition.

Colonel Martin: I would like to clarify this one point, whether we should discharge a limited duty man under 293 at any time during his progress when the medical officer felt he is able to do his duty to which he was limited.

Dr. McCloy: I would feel the special assignment man should be discharged after full reconditioning. It is obvious that we cannot hope to send every man out as a general service man. There are some who are going to go into the hospital and go out as limited service men when they have reached a state of physical condition which will permit them to resume the duties which they performed prior to going into the hospital and when their general physical condition is satisfactory I would discharge them. That may be stretching the point a little bit. We could say the man is a clerk. He comes back with a broken leg. That man could possibly go back and do clerical work but he would obviously be in an unsatisfactory general physical condition. I think that man should be brought up to a satisfactory general state of physique and then discharge him and not try to make a general service man out of him.

General Baylis: I am afraid I have been a little misunderstood. As I see this, there are just three things we can do with our patients:

1. CDD him and get rid of him
2. Classify him as limited service
3. Classify him as general service

The CDD is, we get rid of him as soon as we reach a decision that he is no longer useful to the military service. When we reach the conclusion or had him long enough that we can reclassify him, he is either going to be limited service or general service. If he is to be limited service he will be trained in one of the services where limited service men will be used.

Dr. McCloy: I agree wholly with General Baylis, that when that man has reached the general physique which we may know, and when a man goes into the hospital because of the loss of a finger, the loss of an eye, or because of defective hearing, he will go out as a limited service man. We must keep the man until he has reached what we state is approximately his normal physical condition and he has reached maximum hospitalization. Now I don't picture at all trying to make cooks, bakers, candlestick makers out of them. I do not favor military vocational training. We primarily want to get the man well from his illness or injury. Secondarily, we want to work into the hospital physical reconditioning, a proper mixture of military training, athletic, and calisthenic assignments to recondition that man physically. Thirdly, we want to engage his mind with constructive thinking to keep him from becoming introspective and lose his interest in military matters. We want to keep up his mentality. But I have no thought at all that we are going to hold that man for one minute to make Infantrymen, Cavalrymen, or others after he has reached maximum hospital improvement for the condition for which he was admitted and has reached a general satisfactory state which will permit him to go back to the assignment which we think is appropriate for him.

Q. How is the reconditioning program integrated with the activities of the ward surgeon, for example ward rounds, dressing, etc.?

A. (Major Preston) The way we have Grade III and IV programs set up here, the ward surgeon is not interfered with. He can make rounds on all possible cases at any time during the reconditioning hours. We have had the feeling, of course, that this is a hospital and the patient's treatment comes first, so we have used teaching methods in which the patient works as an individual and it is possible for the ward surgeon to do his work whenever he has enough time.

Q. Will the Reconditioning Officer be able to be in charge of physiotherapy and occupational therapy?

A. (Colonel Thorndike) I think that is a matter of occasion and the hospital commander has to make up his own mind. However, in my opinion, physiotherapy is under Professional Services and occupational therapy is under the Reconditioning Service, but there must be close liaison between these two functions.

Q. Is exercise postoperatively liable to cause embolism?

Major Preston: This is a question we could spend the rest of the evening discussing and still be equally divided. The way that question would be answered is, it depends on whether or not you believe in keeping postoperative cases in bed a long time or if you believe in getting them out of bed early. Personally I believe a little judicious exercise very early might have the effect of preventing phlebitis or thrombosis. It certainly is a debatable question and I do not think there is any use of debating it at this time.

Q. Under Circular 30 how may the assignment of limited duty wounded officers to reconditioning units be accomplished?

A. (Colonel Childs) I looked up Circular 30 and am unable to determine whether it is a War Department Circular, or ASF Circular. If it is an ASF Circular, I have been unable to get a copy. However, in my opinion, the assignment is simple. If under War Department jurisdiction, and you know who the man is, it can be handled by requesting his assignment. If it is for a category of officers only you can make known your wants in those particular categories to ASF Headquarters and they will make a determined effort to get the type of man you want. I presume that possibly you mean the method of obtaining the transfer of an officer from one service to another—from Ground Forces to Army Service Forces, that must be done by ASF Headquarters provided an agreement is reached with the Ground Forces and Air Forces. General Hillman has brought up a question that may clarify the rules if an officer is not qualified for limited service. He must appear before an Army Retiring Board. The appearance of an officer before a Retiring Board does not mean he is relieved from active duty. Even though he may be retired, he may be returned to active duty upon the direction of the War Department Separation Board, which is now headed by Major General Bright. In making this decision, the War Department Separation Board is governed by the Secretary of War and the need of the army for the particular qualifications of the officer concerned. The army, having reached its peak, means that the assignment of any officer must generally be accepted by the relief of another officer. The Separation Board is fully informed of the special needs of the army and governs itself accordingly. If you need these officers, and want them for assignment for this purpose those wants will be made known, and the Separation Board will act accordingly. Even though they may have retired him, they will call him back to duty at your request.

General Bastion: (Read Paragraph 4, ASF Circular 30). But the point is--you may try to get one and are turned down.

Colonel Martin: Your opinion is that these men will go before a Disposition Board and will be recommended to appear before a Retiring Board and the Retiring Board will find them fit for duty, then they will be assigned to that duty? Twenty thousand are retired, twenty thousand can't be returned to duty; therefore, I feel that you will get many limited service officers that you obviously require.

A. (Colonel Thorndike) If it were a particular individual, yes. Likewise, in the case of a particular individual who needs a number of officers that need would be made known to the War Department and they would be so detailed.

A. (General Baylis) If the officers are good enough the Ground Forces are going to keep them. We had a man who was shot down in Italy, who lost an arm. He was outstanding, but he has gone back to Benning as an instructor. I couldn't get him.

Q. Please define the "Patient Status" of Classes I and II in their relation to Supply --Quartermaster V.s. Medical Supply. One interpretation of Circular 168 refers supply problems to Quartermaster, although their "Patient Status" should permit use of Medical Supply facilities.

Colonel Thorndike: Will the individual who wrote that question define what phase of supply he is interested in? It sounds as if it were clothing.

Captain Goldenburg: That is exactly right, clothing and personal laundry, too, for that matter.

A. (Colonel Martin) These people are still patients in the hospital and should be supplied just the same as anybody else. If you have an ambulatory case and he needs a pair of shoes, he can draw from the hospital just the same as an enlisted man. If in a General Hospital, you have all his records and his service record and his clothing account. If it is a station hospital, there is a unit there; and he goes back to his unit and draws any Quartermaster article he needs.

Captain Goldenburg: To clarify that question a little further-- if the Quartermaster were responsible alone to clothe that man, then the man himself would be responsible for the laundering of his clothes. If he is a patient, the Medical Supply would have the responsibility of the laundering of his clothes. This individual is still on the sick report and should be handled the same as any other patient as far as laundry is concerned.

Colonel Thorndike: As long as they wear "GI" clothing instead of bathrobes and pajamas.

Captain Goldenburg: The question was raised in our hospital and according to the ruling in 168, he was not responsible, as all matters of supply came to the Quartermaster and that was the reason for my question. Colonel Thorndike, for the reconditioning division, you may have to get supplies from a lot of people. You are talking about individual supplies, are you? Well, I would say we will look at 168 with a keen eye and see if we have made a mistake. The same rule should apply to that man the same as to many in the hospital.

Q. (General Baylis) There seem to be many men returned from overseas who might well be retained and treated in the overseas theater. Is there a definite policy regarding the type to be returned?

A. (General Hillman) The Surgeon General has sent representatives from other divisions of the War Department to ports of debarkation who see men disembark from overseas theaters; and, from their reports, it seems that there are people sent back who might well be retained overseas. I also feel that we should not be too quick to criticize the people on the other side. They should know whether or not a man is capable of rendering a service overseas more than we would be from seeing him get off the boat because they have been dealing with that individual overseas and are in much better position to know his condition. The War Department's policy is that individuals will not be sent home who can be utilized in general service, or limited service, overseas.

Q. Is educational reconditioning an adjunct of the Reconditioning Program, or has it objectives of its own?

A. (Major Benbow) Education is both a part of the Reconditioning Program and also a general program throughout the Army. It is both.

Colonel Martin: At this point, we are getting along a little past the middle of the program. There may be some questions that have come up in the minds of some of you that you would like to get in now, and have answered.

Colonel Krafft: I would like to know if the program takes care of venereal diseases.

A. (Colonel Thorndike) To an extent, yes. Are they isolated cases, or not? We will not go into communicable diseases in this program.

Colonel Krafft: We had anticipated putting in a very thorough Reconditioning Program in the venereal ward, in the GC ward especially.

Colonel Thorndike: How large is this ward?

Colonel Krafft: Pretty large.

Colonel Thorndike: I think it is up to you.

Colonel Martin: There isn't any venereal problem any more. These patients don't stay in the hospital long enough to require reconditioning. With Penicillin they will be in and out in a very short time so the problem has solved itself.

Q. (General Baylis) The policy of evacuation is not clearly stated to me. That is, if a man is sick today and you expect he will be sick for 6 months, what do you do with him? Does it reach into the Reconditioning Program? My primary objective would have to do with 6 months' treatment. You still misunderstand

me with reference to overseas. Do you return all cases you expect to require 6 month's or more of treatment?

A. (Colonel Martin) It all depends.

Q. (General Baylis) Do you recondition all cases you expect to require 6 months or more treatment? Is that the policy? All cases who require 3 months or more, or isn't there any policy as far as time is concerned?

A. (Colonel Martin) There is no policy so far as time is concerned. Please give consideration to the thought that the earlier a patient gets to Class I and II, the more effective is the program—so much so that he may still require physiotherapy, dental care, etc., when he gets there. This being so, a barracks separated from the hospital presents additional problems.

Major Preston: As I understand the Class I and II patient is one who does not require treatment, so at this hospital any Class I and II patient does not get any treatment except for occasional physiotherapy, dental work, or some other occasional treatment. But, I certainly believe that the patients in Class I and II should be separated from the hospital—in the same premises, possibly, but not in the active wards.

General Hillman: I should like to express a view point, my conception of much of the work being carried on in the advanced Reconditioning Section. I feel that the athletic work which is to limber up shoulder joints or hips is really in a sense treatment. You may have patients in your vast Reconditioning Section who may have bad ankles and have to walk on sloping boards. I feel that this is something in the way of treatment and does get supervision even though the man is in the advanced Reconditioning Section.

Q. What should be the policy in reference to furloughs for soldiers returning from overseas duty and considered returnable to duty?

A. (General Hillman) I think the matter of furloughs has been mentioned several times today, and it is my belief that we are all agreed that, in general, a man is a more difficult problem after he has been home for a month on furlough. I believe this applies particularly to the cases returned from overseas who are battle casualties. Those individuals are showered with sympathy, made heroes, and naturally their families and friends feel they have done their part in the war and moreover they are offered positions that are attractive and when those individuals come back to the hospital they are more difficult to handle. I am speaking of the rule. It is a little bit difficult to decide this. After a man has been overseas for a year or two, it is his greatest desire to get home regardless of what effect it may have on him. It is my belief

that it is better to explain to that individual that if we give him a furlough now, in the first place we do not feel it advisable, so far as his physical condition is concerned, for him to defer further treatment of his case for two or three weeks or even a month. Moreover, if we give him a furlough now, he will not be able to get a furlough at the end of his period in the hospital. The directive is now written that following his discharge from the hospital, providing that he had no sick leave, he will be transferred to a reassignment center nearer his home, and they will give him a furlough of 20 days exclusive of travel time. It would seem to me that the best policy is to try to present to the incoming patient those facts and try to get down to treatment as soon as you can. Have him understand that the quicker he finishes treatment the quicker he will be able to get a furlough.

General Baylis: May I disagree with my good friend. I don't think there is anything the soldier is more interested in than seeing his own folks. When we deny this privilege, we reduce his morale at least 50% and possibly more. This is my own personal opinion. These men who can be granted a furlough when they are returned should be given a short furlough of 10 days. Let them go home, then let them come back and carry on. Otherwise, he will never understand--you can never explain to him or his people back home.

Colonel Thorndike: My own opinion as to the furlough is that it is the Commanding Officer's privilege and right to issue the furloughs and I heartily agree with General Baylis, as I think the man from overseas should have a furlough. Let him start his reconditioning when he gets back.

Major Preston: I believe from the experience we have had here that the soldier should have a furlough, if at all, immediately after his entrance into the hospital, if his condition permits. But, after he gets started in the Reconditioning Program, it upsets the program tremendously to let him get away. We have tried both ways. After giving the men liberal furloughs, they get to think more about when they are going away rather than getting themselves fit. We haven't had any trouble with the men since the furloughs in the Reconditioning Class I and II have been eliminated.

Colonel Childs: I am certain that the War Department would never agree to prohibiting furloughs to a man either upon his entering the hospital or upon completion of his stay in the hospital. The question as to when you would give it to him is open for discussion.

Colonel Martin: That is what the question is about--whether early, before treatment, or after treatment.

Colonel Childs: I think the War Department would be greatly influenced by the experiences of people who are handling this

Reconditioning Program.

Colonel Martin: I think we have had a lot of experience in giving furloughs. After all, the soldier is very proud. It doesn't appear that civilian morale would be boosted by the wounded soldier coming home looking like something the cat had dragged in. Tell them that the reason is they require a definite line of treatment which was designed to get them well and they would get something that would be worth a great deal to them from the standpoint of returning them to duty. Emphasize how much better it would be to return to their families looking like a soldier and stimulate in them a certain pride to want to go back looking like soldiers.

Lt. Colonel Snelling: I think from personal observation, with Colonel Southard, we can definitely say the situation as our policy now stands, which is not granting furloughs after these men are in this hospital for a sufficient length of time to start treatment and they have gotten into Class I and II, which evidences a pretty sound policy because we are not getting disgruntlement, and morale is good and they are not going AWOL. In my few extemporaneous remarks today on public relations, I doubt seriously if I got over the point, but I think it might be carried into this thing. I fully realize we can't discuss in the newspapers or over the radio a matter of policy of the War Department as to what we are going to do about furloughs. I tried to bring out that our public relations build-up as to what we are trying to do for these men will create in the minds of the public the necessity for these men to go into this program without interruption and when they return, after that is completed, they are in so much better shape mentally and physically to enjoy the time they spend with their families and friends. I am very much of the opinion that it would compensate for the postponement of furloughs.

Colonel Martin: I agree entirely with General Hillman that it is a very important matter, deserving full consideration, and it would be advantageous to develop a uniform policy during the next few months. It is something we should all give thought to.

Q. Under Paragraph 4a, Circular 73, no provision is made for a Physical Reconditioning Officer and such provision should be made.

A. (Colonel Thorndike) The paragraph referred to states that there will be one Captain, MAC, and one Lieutenant, MAC, for the first one hundred trainees in Classes I and II and an additional Lieutenant, MAC, for each additional one hundred trainees. He is the Physical Reconditioning Officer. I think that was General Bastion who asked that question.

General Bastion: Give me time to do a little home work. That officer must be a trained officer and we don't have one.

Colonel Thorndike: You mean they should go through this course?

General Bastion: This thing is getting so vast and complicated--he should be nominated by name--such as Orthopod, E.E.N.T., etc. This man should have a level head on him and should know his "onions".

Colonel Thorndike: You remember the chart--the Physical Reconditioning Officer? Well, appoint him. You are a Commanding Officer, you have someone in charge of your I's and II's, haven't you? Is he the logical man? He should be. You have your Reconditioning Chief and your Reconditioning Officer under you.

General Baylis: You know this set-up is all on paper yet. We have been promised a lot of things we haven't gotten. This program is fine on the chart, but we do not have the officers yet, nor the trained men, nor has the ceiling been raised so we can get the officers.

Colonel Thorndike: Who is the one to raise the ceiling?

General Baylis: My immediate chief.

Colonel Thorndike: The circular says the General will set up within his command, his own headquarters, and each hospital of 500 beds, such and such. Also, above current ceiling allotments.

General Baylis: We know that but we haven't got them just the same.

Colonel Martin: The Service Command is making a request for additional personnel.

Colonel Childs: General Somervell would certainly not feel that he was doing the proper thing in arbitrarily ordering officers into a Service Command.

Q. (Colonel Martin) Is it necessary to condition the soldier to the state of heavy muscular power for full military duty? In other words do all soldiers, in order to be good soldiers, have to be prime athletes?

A. (Dr. McCloy) The reason I stress the work of the physical training side of it as important is because it is my assignment. If I were the educational officer in charge of that, I would stick to that. My personal opinion is that the primary thing is to make the man fit to beat the enemy; and any gadgets hooked on not contributing to that should be sloughed off as rapidly as possible. How much we should recondition the man is something that should be looked at with a bit of common sense. Part of the discussion we have has been colored highly by the General Hospital. Suppose we had an ordinary Station Hospital where a man was now out of Class III, who had a clerical job, or something of that sort. I can see no particular reason why, if that station, command, or unit is doing what it is supposed to do in the conditioning of all the soldiers in its regular company routine, he should not be sent back to his company relatively early, put in a Physical Education Program and conditioned there just as the other soldiers, and continue along with them. For example, take a group of paratroopers in very fine condition that have nine months in the service. Or take that one group - here was a man who had some debilitating disease-malaria- or something of that type. You could not send him back until he had picked up sufficiently to go on with his group. I think we will have to look at these things with common sense. Here is a man built like a Clydesdale. That man can very readily put on a tremendous amount of strength. Here is another individual built like a jack rabbit. He will never be able to carry the load of the big fellow. Every individual cannot meet one standard. This Reconditioning Officer will have to use as much common sense as you Medical Officers use, and treat each patient individually. A man returning to a unit should be able to carry the same load as those to whom he is returning. Here is an individual who had been taking too much exercise with his knife and fork before he came into the army. If we kept him in as good a condition as we would like to see him, we would keep him here occupying a bed that someone else needed for the next six months. It is wise to get him in as good condition as possible.

General Baylis: It seems to me that we are going back to the

same thing. Where is this going to end as far as the Medical Department is concerned? If a man is going to be a clerk, where will it end; or an automobile mechanic, where will it end? That is something that is very important in this whole program.

Colonel Thorndike: The metabolic rates have been worked out with various amounts of physical activity. The infantry soldier-metabolic rate is raised 8 times the normal. It is computed that for eight hours he can maintain that rate if he is in condition. For the Marathon runner-the rate is 15 times the normal, but he can maintain that rate for only 2-1/2 hours. The highest rate we know is the sprinter who maintains a rate 20 times the normal, but he can only maintain it for ten seconds, so it is not only reconditioning for a certain amount of work, but is is the duration of the work that counts. The conditioning of the sprinter is a different type of exercise from that of the foot soldier.

Dr. McCloy: Does the company clerk follow his overseas unit across?

General Baylis: Suppose he does, he sits down most of the time. Take an automobile mechanic - just so he can walk to meals and back and can do his job he is all right. A lot of these things we have to consider.

Dr. McCloy: Is it a general policy that the clerk is going to keep this position for the duration, or be suddenly transferred to this and that outfit? If not physically qualified, he won't be?

General Baylis: Correct.

Dr. McCloy: Many of them are switched from time to time?

General Baylis: Correct. General service, limited service, or a desk job.

Dr. McCloy: If he is full service and company clerk?

General Baylis: He has no business being a company clerk. There is a dividing line. First, limited service, then he is fit for general service.

Dr. McCloy: What about a man on limited service because his vision isn't up to normal without glasses? Will limited service mean anything?

General Baylis: There are a good many limited service

men who, when the going gets tough, go on to full service. Some of these men are physically perfect specimens. The Medical Officer who knows the individual makes the decisions. That is the point, where is our objective on this?

Dr. McCloy: You medical people can determine whether this man who is in limited service is apt to stay there. If he is not we could easily transfer him to a desk job and save time if he is not going to meet our standard.

Major Preston: Suppose this man now on limited service has a disability of such a nature that in three or four months it will be improved enough for full service. Should he be recommended for that?

Dr. McCloy: You medical men make these decisions every day. Why not on this?

General Baylis: Where do we end with our physical program? Apparently it is going to dissolve itself from general service to limited service. What about this Profile System?

Dr. McCloy: I never heard of it.

Q. (Colonel Martin) Will there be an automatic allotment of funds for remodeling of existing buildings into shops and class rooms and for purchase of equipment? Will personnel allotment be made automatically and as prescribed in Manning tables?

A. (Colonel Thorndike) This is to be taken up with the Commanding General of your Service Command. I think you will agree with me that there will be no automatic allotment. There has never been an automatic allotment, and I doubt that there will be.

Q. (Colonel Martin) Men who have been reconditioned are often sent to duty with a discharge fitting them for only certain types of duty. They often return to general hospitals with the story that they were required to do full duty.

A. (Colonel Childs) That is unquestionably true, but every time it happens it is a mistake. He should return to the hospital for reassignment and I would suggest an informal investigation and that the facts be placed before the proper echelon of that command.

Colonel Beck: Two weeks ago we received a letter from the Surgeon General's Office asking that we mimeograph a sheet and send in to them pertaining to certain officers who would not go back to full military duty but who do have special qualifications.

General Hillman: Was that letter signed by General Rankin in Washington?

Colonel Beck: Yes.

General Hillman: The Secretary of War and the Chief of Staff met an officer down at the hospital one time who said that if he could only do some work, with only a little of physical therapy once a day to fill in his time, he would be much happier. The Chief of Staff felt that consideration should be given such officers who face long hospitalization and have more time than anything else. He has taken that up with the Surgeon General and wondered if such officers could not be made available for assignment. In Washington, for instance, they could have treatment at the General Dispensary in the Pentagon Building, or possibly go to Walter Reed for a weekly check-up.

Colonel Beck: We had that happen. Lieutenant Bell went to the hospital.

General Hillman: That is what precipitated this question.

Colonel Beck: We report these things - when may we expect action on them, and what should we do? Men with special qualifications who will require long treatment - what should we do pending this? Nerve injuries and such cases, who will require treatment for a long period of time?

General Hillman: I know about the case. In the meantime I think you should continue to give that man treatment to expedite his recovery as fast as possible and pay no attention to the letter except that you have followed your instructions and reported the case.

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This concluded the Panel Discussion, and the meeting adjourned until the following morning.